THE IMPACT OF A STRESS MANAGEMENT PROGRAM ON AFRICAN-AMERICAN FEMALE SINGLE PARENTS UTILIZING CONTROL FOCUSSED THERAPY

By

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This dissertation is dedicated to the following:

To my dear and precious daughter Belinda-Rose who, as an infant in my first year of doctoral work, kept me awake most nights and who later as a toddler would often climb into my lap and say, "Daddy I wish I could help you write your paper." I hope that in some capacity she will continue the research begun by this study.

To my parents, Henry and Ruth James, who have instilled in all their nine college-graduated children, the value of learning, wisdom and professionalism. The last child having begun his university career at 14, and at 21 is beginning a Ph.D. program.

To my current and former patients from whom I have learned so much about life. Their struggles, insights, and the regaining control of their lives, have shaped much of the development of Control Focussed Therapy (CFT).

Finally, this dissertation is dedicated to the honor and glory of God. It is my prayer that all who read or whose lives are ever touched by the principles of CFT will be blessed.

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This study was designed to assess the effects of a stress management program on African-American female single head of households. The Empowerment, Assessment, and Resolution (EAR) model, based on the theoretical and counseling principles of Control Focussed Therapy (CFT) was utilized. CFT is based on a combination of cognitive-behavioral and systemic theoretical approaches. The dependent variables were parental competence, family adaptability, physical stress symptoms, stress inducing cognitions, general stress, and depression. The independent variables were group (experimental and control), and level of household income (above and below $15,000). The research design used in this experimental study was that of a pretest-posttest control group. Data were obtained and analyzed from the pretest and posttest mean scores.

The participants were 34 Black single parents (who had at least one child below the age of twenty-one) residing in the Tampa Bay area on the west coast of Florida. The age of the sample ranged from the 20's to the 50's. Three quarters of the sample worked above 39 hours weekly. The educational level ranged from persons who had completed secondary school to persons with baccalaureate degrees. The annual income ranged from persons below $10,000 to persons above $30,000.

The researcher designed, developed, and implemented the EAR model. There were three two-hour session workshops held over three consecutive weeks. The sessions were led by a counselor and the researcher.

The data analysis showed that there was a significant difference by group for the dependent variable of general stress, and no significant differences by group for the other dependent variables. There was no significant difference based on level of household income, and no significant interaction between income level and group for any of the dependent variables.

This study demonstrated that it is possible for Black single female head of households who attend a six-hour stress management workshop held over a three week period, to experience a significant reduction in their levels of general stress, utilizing the concepts and techniques of Control Focussed Therapy. There is a need for further research to assess the impact of workshop duration on the various variables, and the effectiveness of the various phases of the EAR model on the dependent variables.

CHAPTER I

INTRODUCTION

Single female headed families are a rapidly increasing phenomenon in our society. The Bureau of the Census (1986), in reporting on the changes in family structure for the past 15 years, stated that the most significant change in family composition was the dramatic increase of single parent families. In 1985 there were 33.4 million families with children. Of this number 8.8 million, or 26.3% were one parent families. This compared to 12.9% in 1970. The report stated that 60.1% of Black families with children were headed by a single parent, compared to 35.7% in 1970. For White families 20.8% of families were one parent compared to 10.1% in 1970.

The Statistical Abstracts of the United States (1989) indicated that in 1980 there were 6,052,000 White, 2,495,000 Black, and 610,000 Hispanic single female heads of households with families. In 1987 the figures had grown to 7,227,000 White, 2,967,000 Black, and 1,032,000 Hispanic. In the total population there was an increase of 2,715,000 or 21.9% single female head of household families. In 1987 there were 32,238,000 children under the age of 18 who lived with a single female with no spouse present.

The rapid rate of increase in single female head of household families that occurred in the 1970's has begun to decrease. According to the Statistical

Abstract of the United States (1991), from 1970 to 1980, there was a 58.3% increase; and from 1980 to 1990, there was a 25.1% increase in the number of families with female heads of household. In 1990 there were 7,306,000 female head of households out of 56, 590,000 White family households. During that same year there were 3,275,000 female heads of households out of 7,470,000 Black family households. There were also 1,116,000 females head of households out of 4,840,000 Hispanic family households.

Bould (1977) examined a national longitudinal study of Black and White female headed families to discover the relationship between the level of personal fate control and the provider role in these families. Personal fate control was correlated with (a) amount of income, (b) source of income, (c) economic dependency ratio, and (d) education. On all variables, Black female heads of households were at a greater disadvantage than their White counterparts. Thus, Black female heads of household tend to experience much lower levels of personal fate control, and thus a greater number and measure of stressors, which tend to mitigate their sense of control over their lives.

Some of the problems that female head of household families face include economic hardship, role overload, employment issues, social isolation, feelings of loss and grief, parental control, relationship with the non-custodial parent, lack of managerial skills, and time management (Bray 1982, Buehler & Hogan, 1980). The above factors lead to stress, not only within the single female parent, but also within the entire family.

In addition to the above mentioned factors, Black female single parents experience the stressors of racism and widespread poverty. McAdoo (1982) noted that the stress experienced by Black families brought on racism, tends to be ignored by Stress Questionnaires. She indicated that the Holmes and Rahe scale has no dimension for the racism and discrimination prevalent in our society. If there was such a scale, then many Black families would obtain scores which would indicate severe stress. In her interviews with Black families, many parents reported experiencing extra stress because they were Black.

Black single parents who are stressed tend to, among other things, (a) experience less control of their fate, (b) engage in stress-inducing cognitions, (c) have lower levels of self competence, (d) experience unbalanced levels of adaptability in their family relationships, (e) have high levels of physical symptoms, and (f) experience depression. There is, therefore, a need to aid Black female heads of households to improve their level of coping processes in response to the various stressors that they face. This coping ability, especially that which relates to the mediating effect of stress on illness, is called hardiness. The concept of hardiness focuses on three variables: commitment, attaining a sense of control over one's fate, and the ability to define stressors as challenges rather than threats (Lazarus & Folkman, 1984).

The economic hardship and distress that face many female-headed households are enormous. Hodges (1986), quoting Flyn (1984), indicated that

the single-parent family is the newest factor that contributed to the higher levels of poverty seen in recent years. Women and children constitute 75% of the poor. Only a small percentage of men pay child support. Of those who do pay, the amount given tends to be less than half the real cost of child raising.

Bane (1976) indicated that female-headed households with children suffer significantly greater economic deprivation than female-headed households with no children. Colletta (1983) in discussing the stressful lives of female heads of households noted, "Poverty is, in and of itself, an influential stress factor, but it also generates stress in many other areas of family life" (p. 20).

The U.S. Bureau of the Census (1991) stated

> In 1989, Black families were three and one-half times as likely to be poor as White families. This ratio has not varied much since 1969 when 27.9 percent of all Black families and 7.7 percent of all White families were poor. . . . The poverty rate for Black families with female householders with no spouse present has varied widely during the past twenty years, ranging from 61.6 percent in 1987 to 46.5 percent in 1989. . . . In 1989, 4.3 million or 43.2 percent of all Black related children, and 7.2 million or 14.1 percent of all White related children under 18 years of age in families were poor. (p. 15)

Hodges (1986), in summarizing the study of Hodges, Tierney, and Buchsbaum (1984) on marital status and economics, stated

> For children from intact families, rated adequacy of income had no effect on levels of anxiety and depression. For children of divorce with adequate income, the level of anxiety and depression was the same as for children of intact families. Children of divorce with families with rated inadequate income had substantially higher levels of anxiety and depression than the other three groups. (pp. 54-55)

Emery (1988), discussed the need for greater societal awareness and for many bolder measures and actions to be taken regarding the economic plight of single female heads of households. He indicated that in 1948, 25 of every 1,000 children receiving aid through the Aid to Families with Dependent Children (AFDC) was due to the death of the father. Presently almost 90% of AFDC recipients have an absent parent who is alive. Emery (1988) stated, "In general, families headed by single mothers are more than three times as likely to be impoverished as those headed by a married couple" (p. 100).

Role overload is another factor that contributes to the stresses experienced by many single parents. Lewis and Cooper (1983), in discussing the stresses of combining occupational and parental roles, noted that the concept and tradition of the mother giving her primary allegiance to parenting creates much role conflict. Kamerman (1980) observed that single mothers see work as an important vehicle for social relationships and other life experiences. This observation suggests some basis for the great levels of conflict and stress that face single female parents. The need for a higher level of income, coupled with the need for social interaction with persons from outside the home and the need to fulfill the parenting role and its various demands, leads to intense stress due to role conflict, both qualitative and quantitative.

Burden (1986), wrote on the impact of multiple job and home life responsibilities for single parents, and concluded that "single female parents experience the greatest amount of difficulty with their situation, not because of

their marital/parental status, but because that status leaves them at highest risk for high role strain, which is the major factor related to decreased emotional well-being" (p. 41).

This study consisted of the design, implementation, and analysis of the effects of a stress management program for single female parents, using the intervention principles of Control Focussed Therapy (CFT) (James, 1991). This approach has been demonstrated to be very effective in stress management (James, 1992). Control Focussed Therapy utilizes cognitive-behavioral and systems theoretical frameworks to comprehend human behavior and provides cognitive, behavioral, and systems approaches to enable persons to take control of their lives and thus lessen their degree of stress.

Statement of the Problem

Stress among Black single female parents is enormous. Role overload, economic hardship, social isolation, maternal employment, parental control, and racism contribute profoundly to the level of stress experienced by these parents. The income of Black female heads of households is lower than that of Black male, White female and White male heads of households. In the past 23 years there has been a paltry increase of $300.00 in the annual average income of Black single female heads of households (U.S. Bureau of the Census, 1991). Thus, Black single parents are under the constant pressure to be employed. A great number of these single parents hold two jobs in an

attempt to balance the family budget. McAdoo (1982), in discussing Black families, noted the contribution of maternal employment to the high levels of stress, especially when rearing small children. The impact of this stress on their social, physical, emotional, and psychological well-being can be debilitating.

Maternal stress also impacts children in terms of behavioral problems. Wertlieg, Wiegel, and Fieldstein (1987) noted that there is a very strong relationship between behavioral problems and stress of postdivorce families. Khoe (1986) reviewed literature on the psychosocial adjustment and cognitive development of children of one parent homes. She found that parental stress and the quality of the parent-child relationship were among the critical variables that determine the degree of the children's adjustment.

High levels of stress among working female heads of households tend to increase the risk of physical and sexual abuse of the children of these households (Tableman, 1982). Levels of stress among single-parent families have also been strongly correlated with lower academic performance (Wyman, Cowen, & Hightower, 1985).

Various methods and approaches have been used in stress management programs. Some approaches include: the circumplex model by Olson and McCubbin (1982); the ABCX Model by Hill (1949); the appraisal based theory by Janis and Mann (1977); rational-emotive therapy by Ellis (1962); systematic desensitization by Wolpe (1958); cognitive-behavior by Beck (1976); and stress

inoculation by Meichenbaum (1977). This study adds to the research on stress management by utilizing control focussed therapy (James, 1992).

Need for the Study

As previously mentioned, Black single female parents face astronomical levels of stress. Stress and strain overload have a damaging and negative effect not only on the female single parent, but also on the other members of the family. Violence and child abuse tend to occur more often in situations where single female parents experience high degrees of stress. Although Black single female heads of household carry the highest levels of stress of all heads of family household types, very few studies have addressed the stress management issues of those families (Allen, 1986).

In this study, the researcher utilized Control Focussed Therapeutic approaches to address the levels of stress in Black single female parents. The stress management program did significantly augment the level of hardiness experienced by female single parents. Thus, Control Focussed Therapy has the potential for increasing the well being of a continuously increasing segment of the population.

Purpose of the Study

An experimental study was conducted to investigate a stress management program for Black female single parents, utilizing the Control Focussed Therapeutic approach. The stress related variables studied were parental sense of competence, family adaptability, stress physical symptoms, stress cognitions, general stress, and depression. It was anticipated that a reduction in the levels of stress experienced by single female parents would lower the stress experienced by the children of these parents.

Theoretical Framework

This stress management program was developed on the therapeutic intervention principles of Control Focussed Therapy (James, 1991). The researcher has developed two models based on the principles of CFT. The first model is the Sexuality Integration Approach (SIA), which is used to aid persons with various sexual disorders or who have been sexually abused. The second model is the Empowerment, Assessment, and Resolution (EAR) model, which is used to aid persons with adjustment, mood, anxiety, and personality disorders.

In this study the EAR model was used to address the stress levels of Black single female parents. James (1992) reported on a study which utilized the EAR model. Significant differences were obtained between pretest and posttest on the dependent variables of stress and depression, respectively, at the .01 and .05 levels of significance.

The theoretical framework undergirding this study is that of Control Focussed Therapy, which utilizes cognitive-behavioral and systems approaches (James, 1992). Control Focussed Therapy brings a holistic approach in analyzing and explaining human behavior. CFT maintains that human beings as biological organisms are constantly faced with fulfilling their physical, emotional, and spiritual needs for survival (Maslow, 1968, 1970). This need for survival propels persons to desire to take control over their lives. However, taking control over one's life can be a great challenge, especially when there is a chasm between one's expectations based upon one's needs and societal expectations, and the reality of one's situation. This gap between our expectations and our reality is called the "cognitive gap." Personality develops as individuals attempt to manage this cognitive gap. The personality style of the individual determines the degree of success in managing the cognitive gap. In the CFT approach, the various personality styles of Millon (1969); Millon & Millon, (1974) are utilized in assessing the individual's approach to managing this cognitive gap. All of life consists of attempts to manage and control this cognitive gap. Healthy cognitions and behaviors enable persons to manage this gap and thus maintain control over their lives. Such persons live healthy and successful lives.

Functional pathology occurs when persons experience various degrees of difficulty in managing their cognitive gap. Persons who engage in decontrolling thoughts and behaviors and who do not successfully manage their

cognitive gap, tend to experience (a) disquiet, which can lead to (b) stress, which can lead to (c) anxiety, which can lead to (d) anger, which can then lead to (e) depression. Persons who do not successfully manage their cognitive gap, usually display dissonance in three major dimensions of their lives. Those dimensions are self-esteem, sexuality, and stress.

In CFT, therapists focus on changing maladaptive behavior by enabling persons to manage and adjust the level of their cognitive gap. Individuals need to manage their cognitive gap in order to maintain healthy emotional, spiritual, and behavioral functioning. In the process of counseling, clients examine the contributions of themselves and society's expectations to their cognitive gap. Their personality style as it contributes to their affective, cognitive, and behavioral modes of operation are discussed. The goals of this therapeutic approach is to enable persons to (a) take control of their lives; (b) take responsibility in meeting the various needs for their emotional, spiritual, and physical well being; and (c) take loving care of themselves. The management of the cognitive gap is taught and demonstrated through a series of cognitive-behavioral and systems approaches. Cognitive therapy has been found to be very successful in the treatment of stress (Beck & Emery, 1985). Freeman and Greenberg-Zaken (1989) in discussing the use of cognitive-behavioral models in stress management stated, "Cognitive therapy is an ideal approach for the treatment of stress in the family. It is short-term, directive, collaborative, psychoeducational, and dynamic model of psychotherapy" (p. 101).

Meichenbaum (1977) advocated a form of cognitive-behavior therapy, where the emphasis is on cognitive restructuring. In this mode, in which the person's distress results from faulty thinking, the individual becomes aware of the negative self-statements and learns new problem-solving and coping skills. Persons are then encouraged to engage in positive self-statements and self instruction.

Cognitive-behavior therapists explain family behavior as molecular arrangements, while systems therapists explain family functioning in terms of circular processes which occur mainly on the molar plane (Minuchin, 1974; Patterson, 1982; Robin & Foster; Stanton 1981;). In this study, the structural and hierarchy arrangements within families will be used in the development and implementation of a stress management program.

Freeman and Zaken-Greenberg (1989) in discussing the theoretical framework for cognitive-behavioral approaches, indicated that the major focus is to enable clients to examine their constructs of the world and to encourage them to respond with new behaviors. They further state, "A major goal of therapy is to increase the client's skills so that he or she can more effectively deal with the stressors of life, and thereby have a greater sense of control and self-efficacy in his or her life" (p. 101).

Various studies have focused on the family as a homeostatic system. These studies examined family conflict, and conclusions have been drawn that

a focus on problem solving communication and cognitive distortions are effective in reducing the level of family conflict (Robin & Foster, 1989).

Systems approaches have also been used in stress management. Nichols (1989) in discussing the usefulness of systems approaches in stress management stated, "Several factors . . . make a family systems approach especially appropriate for use with unusual and extraordinary stress. . . . A family systems approach is particularly well suited for dealing with separation and divorce situations which, after all, involve the breakup of one family subsystem" (p. 73).

The systemic approach to family evaluation examines the interactions between family members and the impact such interactions have on the various members of the family system. Family violence and child abuse are linked to stress within the family. McCubbin, Joy, Cauble, Comeau, Patterson, and Needle (1980) in discussing issues on family stress and coping stated

> Investigators have turned their attention to violence in the family, child abuse and neglect. . . . Abuse is viewed, in part, as a result of stress and frustration in the family unit which, in its extreme, manifests itself in physical harm to family members, usually children. (p. 859)

It is envisioned that as cognitive-behavioral and systems techniques are used in the EAR model and parents discover and implement new approaches to take control of their lives, their levels of stress will decrease. It is hoped that this decrease in the stress levels of parents will mitigate the levels of stress experienced by the members of their families.

Nichols (1989) discussed family systems approaches and noted that in these approaches emphasis is placed on persons in their primary context, which is the family. Problems and stressors are examined in terms of the overall family functioning. Thus, in terms of separation or divorce, the focus is on "family reorganization in systemic terms, rather than as outcomes of individual neurosis" (p. 68). The family system has not ended, but has been affected. There is a need to deal with the structures of the new system. He further indicated that it is important to recognize that family members do not have to be present in therapy for them to be affected by what occurs in therapy. The important factor is that the clinician and client need to think in terms of the family dynamics as therapy occurs.

Nichols (1989) in discussing the appropriateness and usefulness of family systems approach to working with family stress noted

> A family systems approach is particularly suited for dealing with separation and divorce situations. . . . Separation/divorce represent for many couples and their families a stream of prolonged emotional stress with alternating rapids and whirlpools. . . . The amount of stress occasioned by separation/divorce depends on several factors. These include not only whether the change is desired by the participants but also the stage in the family life cycle at which it occurs. (p. 73)

This EAR model addresses the following stress related variables: parenting sense of competence, family adaptability, physical symptoms, stress cognitions, general stress, and depression. This approach focuses on enabling persons to take more control over their lives and to take more responsibility in fulfilling their various emotional and physical needs for healthy functioning.

For the intervention principles of CFT to be effective with various population groups, attention should be paid to the various dimensions of world views that persons possess. Sue (1981) defined world views as the manner in which persons view themselves as relating to the world. An individual's world view determines how he/she thinks, behaves, or feels. Black single female parents face in addition to the general stressors of single parenting, the issue of racism and its attending ramifications. Racism relegates persons to inferior positions. In response to the endemic racism in the social, economic, and political structures, Black single parents experience low levels of personal fate control and low levels of responsibility for the events which transpire in their lives.

There are two major dimensions of world views that need to be attended to when working with various minority groups. Rotter (1966) described the dimension of locus of control with an internal-external dimension. Persons on the internal end of the spectrum see a positive correlation between their actions and their fate. Persons on the external dimension see no such positive correlation. Structural racism has propelled many Blacks to operate on the external dimension. Control Focussed Therapy is culturally relevant because it focusses on enabling persons to operate on the internal end of the locus of control dimension.

The second major dimension of world views is that of locus of responsibility. Jones, Kanouse, Kelley, Nisbett, Valins, and Weiner (1972)

indicated that persons lie somewhere on the person centered-situation centered ends of the locus of responsibility spectrum. Individuals who are person centered tend to see a positive correlation between their ability, effort and success. Persons who are situation centered view the political, social, and economic structures of society as constantly overpowering their efforts for success. Structural racism has again propelled many low income Blacks to operate on the situation centered end of the spectrum. Control Focussed Therapy is culturally relevant in that it does not deny the reality of the social, economic, and political forces in our society. However, through the process of CFT persons, are enabled to examine and select various options for self fulfillment and healthy functioning.

Sense of Competence

Lazarus and Folkman (1984) have indicated that in our society, women are to a greater degree victims of learned helplessness. Thus, they feel less control over their lives. This lack of control contributes to the levels of stress that they experience. It is therefore important in designing a stress management program for women to enhance their level of self competence. Teti, Gefland, Donna, and Pompa (1990) studied 59 mothers and their interaction with their infants who were 3-13 months old. They reported that the level of parenting competence was inversely related to the stress levels of the mothers. Emery (1982, 1988) supported the efficacy of the cognitive-behavioral approach in working with women to enable them to control their cognitions and

thus attain a sense of mastery and power over their lives. Women need to cognitively and behaviorally master their symptoms to attain a sense of power.

Family Adaptability

Olson, Portner, and Lavee (1985) defined adaptability as "the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress" (p. 4). As has been previously noted, maternal stress impacts on family stress. It is therefore important that this study empower single women to attain a balanced level of adaptability and thus help in mitigating the levels of stress experienced by the entire family.

Minuchin, Rosman, and Baker (1978) discussed the use of the systems structural approach in initiating change and adjustment in highly stressed families. In one study 50 anorectic patients and their families were treated. Follow-up studies over a ten year period indicated that 86 percent of the patients had received a rating of good in terms of their satisfactory adjustment in family, school, work, and interpersonal relationships.

Physical Symptoms

Physical symptoms or health outcomes is another variable addressed in this study. Specifically, the issue is to what degree does the coping ability of persons, or their degree of hardiness, affect their level of physical symptoms when faced with stressful situations. Kobasa (1979) and Kobosa, Maddi, & Kahn (1982) compared two groups of persons who had high degrees of stress

as measured by the Holmes and Rahe life event questionnaire. It was found that persons who had a hardy personality were less prone to be sick and required less medical attention. Lefebrve and Sanford (1985) indicated that both exercise and relaxation aid in reducing stress-related physical symptoms. Koeske and Koeske (1990) studied the buffering effects of social support on parental stress on 125 mothers with children aged between 9 months to 14 years. The authors reported that there was a negative correlation between the levels of maternal stress and the somatic symptoms of the parents who had low levels of social support.

Stress Inducing Cognitions

Ellis (1962) indicated that an individual's conception of an event has a greater impact on his/her reactions than is the objective situation. Irrational beliefs or assumptions increase the level of stress experienced by the individual. Thus, it is important to ascertain the level of stress inducing cognitions individuals bring to the various events in their lives. Wetzel (1984) discussed the effects of negative cognitions on levels of stress. She stated, "Negative cognitions are particularly pertinent to women's perceptions of themselves. . . . Women typically anticipate nothing more favorable than their present existence and take the blame for the trauma in their lives" (p. 185). In discussing the use of cognitive-behavioral approaches in dealing with negative cognitions, Wetzel (1984) stated "The fact is that cognitive-behavioral

interventions are more likely to be effective than many apparently richer constructs" (p.188).

Depression

Smith (1985) noted that due to racism and the low historical position that African-American women have been placed, these women experience many mental health-related issues. Thus, African-American women are at increased risk for stress, drug abuse, depression and suicide. Steele (1978) carried out a correlational study of depression, race, and social class. Thirty-four Black women, 32 Black men, 37 White men, and 31 White women were studied. The findings were that female status and lower social mobility were strongly related to higher levels of depression. Weissman and Klerman (1977) indicate that when women and men experience stress, the women are much more prone to be depressed.

Paykel (1989) reviewed various studies on the treatment of depression and noted that the use of cognitive-behavior therapy led to a lower relapse rate than the use of tricyclic antidepressants. McLean and Hakstian (1979) studied the effectiveness of four treatments to enable persons to attain a greater degree of sense of competence and hardiness and to decrease their levels of depression. McGrath, Keita, Strickland, & Russo (1990), in discussing the McLean and Hakstian study, stated

> The authors compared a 10-week course of behavioral treatment with amitriptyline, insight-oriented psychotherapy, and relaxation training. Seventy-two percent of the 178 patients were women. Results showed behavioral therapy to be superior to the other

interventions at the end of treatment and marginally superior at the 3 month follow up. Cognitive and behavioral therapies may be particularly important for depressed women because they teach women to confront and overcome the passive, dependent role they may have been taught since childhood. (p. 59)

Research Hypotheses

1. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' means scores on single parents' reported levels of parenting competence.
2. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of family adaptability.
3. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of stress related physical symptoms.
4. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of stress inducing cognitions.
5. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of general stress.
6. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of depression.

7. After adjustment for pretest scores, there is no significant interaction between the level of the single parents' household income and the effects of treatment on the variables of parenting competence, family adaptability, physical symptoms, stress cognitions, general stress, and depression.

Definition of Terms

The following definitions are used throughout this study:

Anticipatory stress refers to the arousal and individual experiences in anticipation of a coming event (Schafer, 1987).

Cognitive appraisal "is an evaluative process that determines why and to what extent a particular transaction or series of transactions between the person and the environment is stressful" (Lazarus & Folkman, 1984, p. 19).

Cognitive gap refers to the difference between the cognitive expectations and the cognitive appraisal of a situation. This difference can lead to stress.

Cognitive restructuring is the process where "the client is helped to increase his or her awareness of negative self-statements and images and to learn the specific new problem-solving and coping skills" (Lazarus & Folkman, 1984, p. 341-342).

Control Focussed Therapy is an approach to enable persons to manage their cognitive gap through the use of cognitive-behavioral and systems approaches.

Coping "refers to that variety of behaviors, physiological reactions, cognitions, perceptions, and motor acts that control either the demand placed upon the organism directly or the interpretation placed upon its anticipated consequences" (Goldberger & Breznitz, 1982, p. 141).

Depression is a score obtained on the depression subscale on the Beck Depression Inventory.

Family refers to two or more people related by birth, adoption, or marriage.

Family adaptability is a score obtained on the adaptability subscale of the Family Adaptability and Cohesion Evaluation Scales.

Hardiness refers to the degree of possession of three personality traits: commitment, the ability to view situations as challenges rather than as demands, and the belief of controlling one's destiny (Lazarus & Folkman, 1984).

Household is defined as persons living within a single housing unit who share economic resources.

Life stress is a score obtained on life stress subscale of the Parenting Stress Index.

Life style buffers are attitudes, thoughts, and actions that an individual develops to resist periods of distress (Schafer, 1987).

Magnification is the tendency to over estimate the significance of negative events (Beck, 1976).

Organizational stressors are those conditions that exist in an institution that are liable to create distress among its employees (Schafer, 1987).

Physical symptoms is a score obtained on the physical symptoms subscale of the Strain Questionnaire.

Qualitative overload is the state of "feeling overwhelmed by the difficulty of one or more tasks" (Schafer, 1987, p. 341).

Quantitative overload occurs when one feels "overwhelmed by a large number of tasks and stimuli" (Schafer, 1987, p. 341).

Selective abstraction refers to the process where an individual ignores contradictory evidence and forms a judgement based on isolated negative events (Beck, 1976).

Sense of competence is a score obtained on the sense of competence subscale of the Parenting Stress Index.

Stress inducing cognitions is a score obtained on the cognitions subscale of the Strain Questionnaire.

Stress inoculation "means acquiring sufficient knowledge, self-understanding, and coping skills to facilitate better ways of handling expected stressful confrontations" (Lazarus & Folkman, 1984).

Summary

Black single female heads of households are a rapidly increasing phenomenon in our society. They face various problems such as role overload, social isolation, economic hardship, time management, parental control, and racism. The above-mentioned factors generate various levels of stress in these parents. Stress related variables include diminished parental competence, unhealthy levels of family adaptability, the experience of physical symptoms, stress inducing cognitions, and depression. This EAR model of stress management is based on cognitive-behavioral and systems approaches. These approaches have been demonstrated to be effective in stress management programs.

Organization of the Study

The remainder of this study is presented in four chapters. In Chapter II, a review of related literature on stress is presented. In Chapter III, the methodology of the study is provided. This includes the research hypotheses, relevant variables, a description of the population, sampling procedures, the research design, the instruments, research procedures, data collection and analysis, and a summary of the EAR model. In Chapter IV, the results of the study are presented. In Chapter V, there is a discussion and interpretation of the results, the limitations and implications of the study, and recommendations for future research.

CHAPTER II

REVIEW OF EXISTING LITERATURE

This chapter includes a review of the following topics: (a) the historical development of stress theory, (b) the various definitions of stress based on theoretical models, (c) modes of assessment of stress, (d) instruments, (e) maternal stress and family functioning, (f) the theoretical framework and empirical support for this intervention program, (g) components of stress and its management, and (h) the need for stress management programs for female heads of households.

Historical Development

The concept of stress is very pervasive in society today. It is found in the physical, life and biobehavioral sciences. Fuerestein, Labbe, and Kuczmierczk (1986) described the historical development of the concept of stress and noted that in the seventeenth century the term carried a negative connotation. This connotation described the difficult situations which individuals experienced. In the eighteenth and nineteenth centuries, people generally viewed stress as an external force that acted upon individuals. This force tended to distort persons, who then had to try to maintain their stability and integrity (Hinkle, 1974). The biobehavioral sciences have borrowed much from the physical sciences in describing the external forces that act upon objects or

living things. Fuerestein et al. (1986) note three terms used to describe that external force and its effects in the physical sciences:

> Stress represents the ratio of the internal force present when a solid is distorted to the area over which the force acts. . . . Strain, or distortion, is the ratio of the change in size or shape to the original size or shape. Load is the external force producing the distortion. (p. 96)

Physicians and scientists had postulated the relationship between stress, physical illness, and the need for physiological stability. Sir William Osler (1910) believed that persons who lived very intense lives were predisposed to angina pectoris. The French physiologist Bernard (1879) concluded that it was important that the internal environment of living organisms remain constant. He stated "It is the fixity of the milieu inteerieur which is the condition of free and independent life" (p. 564).

A major contributor to the concept of stress was Hans Seyle. In his pioneering work on stress with laboratory animals in the 1930s and 1940s, he discovered the heightened pattern response of the pituitary and adrenal glands. This response occurred whenever any toxic substances, trauma, change in temperature, or psychological stimuli were introduced to the animals. These responses became known as the General Adaptation Syndrome. This syndrome typified the systemic idea of stress, and consists of three stages. The first stage, which is the alarm reaction, has the shock phase (where the resistance is lowered) and a counter-shock phase (where the defense mechanisms of the organism becomes activated). The second stage is that of resistance. Here the organism focuses on adaptation for survival. If the

stressor persists, or the defense mechanism proves to be inadequate, then the third stage of exhaustion ensues, with the collapse of the adaptive mechanism (Appley & Turnbull, 1967). Seyle (1982) stated, "These changes became recognized as objective indices of stress and furnished a basis for developing the entire stress concept" (p. 10).

While Seyle was developing his concept of stress, other researchers, including H.G. Wolff (a physician), began to identify various diseases that they believed resulted from life stresses (Feuerstein et al., 1986). Wolfe described stress as "that state within a living creature which results from the interaction of the organism with noxious stimuli or circumstances" (Hinkle, 1974, p. 339). Wolff defined the noxious stimuli that distorted the structure and function of the organism as unconditional. He classified as psychological stressors those stimuli that acted as signals or symbols of stress on the organism. Appley and Trumbull (1967), in discussing the popularity of stress as a psychological concept, posit three reasons. First, they stated that the term stress had achieved some status as a research topic and that researchers used it as a substitute for other concepts such as anxiety and distress. Second, the use of the term in the biological field enable persons to correlate psychological and physiological data. Third, there is great interest in the various milieu within our society and its impact in generating stress on individuals.

Definitions of Stress

There is wide disagreement on the operational definition of stress. Seyle (1980) stated, "Stress is a scientific concept that has suffered from the mixed blessing of being too well known and too little understood" (p. 127). Elliott and Eisdorfer (1982) stated," . . . after thirty five years, no one has formulated a definition of stress that satisfies even a majority of stress researchers" (p. 11). Fuerstein et al. (1986), also reminded us that "a construct is only useful in terms of its organizing power and explanatory power" (p. 95).

Despite one's theoretical perspective, stress researchers usually recognize the stress experience as consisting of stressors and the stress response. Stressors are stimuli that require the organism to generate some form of adaptation. The response resulting from the stimuli is called the stress response.

Stressors can be external physical stimuli or internal stimuli, such as cognitions and emotions. Fuerstein et al. (1986), in discussing stressors, noted that "(1) they may have positive as well as the more commonly assumed negative valence, and (2) there is considerable variability as to what is considered a stressor across individuals. Positive events may require as much adjustment or adaptation as negative events" (p. 96). Thus, one needs to be aware that what may evoke a stress response in one individual, may not engender the same response in another person.

The stress response consists of physiological, behavioral, and cognitive parameters. The response activates the parasympathetic and sympathetic areas of the autonomic nervous system, which in turn generates various physiological reactions. Fuerestein et al. (1986) stated that

> The stress response has three physiological components: tonic, phasic, and recovery. The tonic component is defined as the resting or basal level of activity in the specific response, the phasic component represents the reaction to a given stressor, and recovery relates to the response following the stressor, and is typically defined as the component associated with returning to the resting or tonic level. (p. 101)

The cognitive aspect of the stress response includes changes in mood that may be manifested in depression, and fatigue. The individual also appraises or assesses the impact of the stressor on self. The response to stress thus generates various coping mechanisms.

The behavioral component of stress involves the behavioral response to stress. This can include facial expressions, hostility, avoidance, impatience, and sexual dysfunctions.

Theoretical Models

There are three major models used in describing and defining the concept of stress. They are the response-based, stimulus-based, and transactional.

Response-based Model

The response based approach focuses on the pattern of responses elicited from an individual experiencing a stressor. The psychological and physiological responses are the stress response, and stress is viewed as an

independent variable. The stress response is non-specific in that it is elicited in response to any stressor. The General Adaptation Syndrome is an example of the stress response model. Thus when the body's resistance to stress falls below certain levels, illness results.

Stimulus-based Model

The stimulus-based model focuses on the stimuli that tend to cause a disequilibrium in the physiological and psychological facets of the individual. As Fuerestein et al. (1986) state" Stress arises from the individual's environment, and the reaction to external stressors is strain" (p. 124). An example of this approach is that used by Holmes and Rahe (1967). They have identified stressful events and developed a scale to quantify the impact of these events on the individual.

Interactional Model

The third approach is called the interactional or transactional model. This model posits that stress is a result of a relationship between an individual and his/her environment. Thus, the individual is actively involved in the stress process. The person appraises the stressful situation and regulates the impact of the stressor by utilizing cognitive, behavioral, and physiological coping strategies. This approach is cyclical. Thus, there is a continuous link between the stimulus, appraisal, coping strategies, and the impact of the stressor. If an individual has inadequate coping responses to the various environmental stressors, then he/she feels overwhelmed, which could lead to depression and

a loss of sense of competence. Distressed persons tend to engage in distorted thinking, adopt rigid postures, and may react to the distress by experiencing physical symptoms.

Cox and Mackay (1978) have proposed five stages in the transactional model. They stated

> The first stage identifies the existence of demands or stressors placed on the individual. The model identifies two types of demands: internal and external. The internal demands relate to the physical and psychological needs of the individual. . . . The external demands represent potential sources of stress that are a function of environmental factors, such as. . . . a family member who constantly requires one's involvement. The second stage consists of a person's perception of internal and external demands and of his or her ability to meet these important needs. Stress occurs when an imbalance between demand and perceived coping ability exists. . . . The third stage. . . represents the stress response, which is a method of coping with the stressor. The subjective emotional experience of stress is accompanied by cognitive, behavioral, and physiological changes that attempt to reduce the demand. . . . The fourth state is concerned with both the actual and perceived consequences of the coping responses. . . . The fifth stage consists of the feedback that occurs throughout the system and may shape events at any point in the system. Feedback of appropriate responses can enhance the individual's ability to adapt. (pp. 126-127)

Theoretical Framework

The theoretical framework undergirding this stress management program is that of cognitive-behavioral and family systems approaches. In the analysis of stress, the following issues related to single parenting are examined (a) the disruption caused in the family homeostatic system by stressed individuals, (b) the family structure and hierarchy, (c) problem solving and communication

deficits, (d) cognitive distortions, and (e) the behavior of each member in the family system (Robin & Foster, 1989).

The behavioral and systems models are two leading approaches in working with families (Robin & Foster, 1989). Behaviorists tend to examine families from a molecular and behavior exchange point of view. (Gordon & Davidson, 1981; Patterson, 1982) However, the systems approach explains the same processes at the molar level, but focuses on cybernetic and structural issues (Minuchin, 1974; Steinglass, 1987). Foster and Hoier (1982) indicated that the common emphasis in both approaches is that of observing patterns in the interpersonal processes.

Systems Approach

In describing the family as a homeostatic system, it is important for single parents to comprehend that individuals and families go through various developmental stages, and that each stage carries with it different potential stressors. Carter and McGoldrick, (1980) discussed six stages of family development. They are (a) the unattached adult, (b) the new couple, (c) family with young children, (d) family with adolescents, (e) launching children, (f) the family in later life.

Family structure examines the organization and power distribution within the various sub-systems of the family. (Haley 1976, Minuchin, 1974) The sub-systems are the parent, parent-child, and the sibling. Power refers to the degree to which persons within the family can influence significant events within

the family. When individuals fail to realize the anticipated power based on their position within the hierarchical system, stress usually follows.

In examining family structure, it is important to comprehend the contribution of alignment to the experience of stress. Alignment describes the joining or opposing of family members to execute decisions. An alignment can consist of a coalition where family members join in concert against another family member. An alignment may also consist of triangulation, where members of opposing parties seek to recruit the third person against each other.

A third element in the examination of family structure is that of adaptation. Adaptation is the degree of flexibility that exists within the family to change its power structure, role relationships, and rules in response to stress at both the developmental and situational levels (Olson, Portner, & Lavee, 1985). It is important to help single parent families attain and maintain balanced levels of adaptability.

Faced with the potential for vulnerability, it is important that families are equipped with adequate coping mechanisms when dealing with various stressors. McCubbin, Joy, Cauble, Comeau, Patterson, and Needle (1980) in their review of studies on family stress and coping mechanisms, noted four fundamental hypotheses that emerged on the necessity for coping behaviors. Coping behaviors tend to (a) mitigate the degree of vulnerability factors (b) augment or maintain family resources (c) reduce the number of stressor events

and their hardships, and (d) involve individuals in influencing and changing their social circumstances.

Problem Solving and Communication

The second pillar of this theoretical framework is that of problem solving and communication skills. D'Zurilla (1988) indicated that effective problem solving, which is a cognitive-behavioral process, needs to follow a logical sequence. Spivack, Plaatt, and Shure (1976) recommended seven skills that aid in effective problem solving: (a) problem finding, (b) problem definition, (c) generation of solutions, (d) evaluation, (e) decision making, (f) implementation planning, and (g) verification.

Problem solving within a family context also requires effective communication skills. Training in the ability to be assertive and to negotiate compromises are vital ingredients in problem solving.

Cognitive-Behavioral Approaches

Cognitive-behavioral approaches focus on the mediating effects of cognitions on the maladjustment of individuals experiencing various levels of stress. Researchers, theorists, and clinicians have posited various approaches.

Ellis (1962) was one of the earliest theorists to use a cognitive-behavioral approach, with his concept of rational-emotive therapy. This approach stated that individuals tend to make faulty interpretations of events. This leads to irrational beliefs, which result in destructive behavior. The goal of this

therapeutic approach is to enable persons to relinquish faulty beliefs that cause distress, and develop a reservoir of sound and healthy thought patterns.

The cognitive approach to stress management presupposes that faulty cognitions can create stressors within individuals. In family interactions there are three aspects of cognitions that should not be overlooked. They are (a) the impact of thoughts on feelings and feelings on thoughts, (b) the fact that cognitions can be processed, (c) the assumptions and themes that underlie faulty cognitions (Robin & Foster, 1989). Some faulty cognitions include arbitrary inference, selective abstraction, over generalization, magnification and minimization, perfectionism, ruination, fairness, obedience, self-blame, malicious intent, and autonomy.

Beck (1976) has presented another cognitive-behavioral approach that can be used in developing a Stress Management Program. He has indicated that depressed persons have a negative view of themselves, the world, and the future. The individuals then become selective and form conclusions on insignificant or isolated detail, or demonstrate arbitrary interference, and draw conclusions in the absence of evidence. They may also over-generalize and obtain a negative conclusion from a single event, or engage in magnification and overestimate a negative experience, or engage in all or nothing thinking. Thus, the individual views life as either black or white.

Meichenbaum (1977) also advocated another form of cognitive-behavior therapy. Here the emphasis is on cognitive restructuring. In this mode (in

which the person's distress results from faulty thinking) the individual is made aware of the negative self-statements and learns new problem-solving and coping skills. The emphasis in this approach is placed on having persons engage in positive self-statements and self instruction. Meichenbaum proposed a stress-inoculation training program to increase the degree of hardiness of individuals when confronted with stressful situations. Lazarus and Folkman (1984) in describing this approach stated

> Stress inoculation means acquiring sufficient knowledge, self-understanding, and coping skills to facilitate better ways of handling expected stressful confrontations. The program has three phases. In the educational phase, information is provided about the way distressing emotions are generated, and emphasis is placed on the cognitive factors or self statements that are involved. In the rehearsal phase, individuals provide alternative self statements for use under conditions of emotional distress. The strategies help the client assess the situation, control unwanted thought and emotions, motivate behavior, and ultimately evaluate his or her performance. In the application phase, the client integrates what he/she has learned and implements it. (p. 342)

Other cognitive-behavioral approaches include modeling by Bandura (1969) and psychodrama (Moreno (1947). Cognitive therapists address not only the cognitive modality, but also the affect and behavior components of persons. Lazarus (1981) calls this multi-sided approach "multimodal therapy."

Cognitive therapists also recognize the multimodal aspects of persons. Thus, Wessler (1982) proposed eight steps in a cognitive-emotive-behavioral event. Lazarus and Folkman (1984) summarized the eight steps that can be a point of intervention as follows:

> (1) The stimulus, internal or external, such as another person's action, a phobic object, or emotion; (2) the individuals' selection of what to attend

> to. . . . (3) the perception and symbolic representation of the stimulus; (4) non evaluative interpretations, which may involve forecasts and expectations about what will happen, attributions, and other cold cognitions; (5) evaluative interpretations of more fully processed information, in effect, potentially hot cognitions; (6) the emotional response to the processed information; (7) the behavioral response, for example, approach avoidance, or attack behavior; and (8) cognitive feedback from the reaction and the reinforcing consequences of the patients' behavior. (p. 359)

Empirical Support for Theoretical Framework

Hetherington, Stouwie, and Ridberg (1971) and Riskin and Faunce (1970) demonstrated that distressed families experience great difficulties in arriving at a consensus when faced with a problem. Robin and Weiss (1980) stated that distressed families demonstrate more commands and put downs and less humor, praise, and problem solving skills than non distressed families.

Schwebel, Moreland, Steinkohl, Lentz, and Stewart (1982) in their review of the effects of divorce on family adjustment concluded that the level of stress experienced by the families can be mitigated by increasing the parents' ability to communicate with their children. Poor communication increases the level of stress in relationships.

Several studies on single parent families demonstrate the positive effect of problem solving and communication training skills. Robin, Kent, O'Leary, Foster, and Prinz (1977) reported that there was a decrease in behavioral problems after mothers and adolescents had experienced training in problem solving skills. Klein, Alexander, and Parsons (1977) assigned court-referred offenders to client-centered, behavioral, eclectic-dynamic, and no treatment

groups. Their conclusion, based on family interaction measures and court recidivism records, was that the behavioral approach using communication skills and contingency contracting was the most effective method.

James (1992) reported on the use of the EAR model with seventeen Black female entrepreneurs. The workshop consisted of four two-hour sessions. A pretest and posttest were given. ANOVA results indicated significant differences at the .01 level for the variables of parental competence, physical stress, and general stress. There were significant differences at the .05 level for the variables of family adaptability, behavioral stress, cognitive stress, cognitive depression, somatic depression, and general depression.

Assessment of Stress

There are various methods and foci in measuring stress. The aspect of the stress experience measured usually parallels the individual's definition of stress. Thus, in measuring the stress experience one tends to focus on either the stressor, the coping/appraisal process, or the stress response.

Assessment of Stressor

In measuring the stressor, one can manipulate the stressor in a laboratory situation, and thus vary the intensity or duration of a stimulus. Stressors which occurred in the past or are present also can be measured. Usually these stressors are identified through the use of check lists, rating scales, or self-report questionnaires, where certain life events or experiences have been rated as stressful. These events tend to disrupt the equilibrium of

individuals. Thus, one measures the degree of life change. A major instrument that measures the environmental and social changes is the Social Readjustment Rating Scale by Holmes and Rahe (1967). Each event is scaled, and the total score indicates the degree of stress experienced by the individual over a period.

Goldberg and Comstock (1980) have indicated that there is great variability among groups of persons in their perception and frequency of life events (Goldberg & Comstock, 1980). Four factors tend to influence the perception of life events. They are age, sex, marital status, and social class. Younger persons tend to obtain higher scores than older persons. Women tend to obtain higher scores than men. Married persons tend to accumulate a lower level of life changes than single persons. Research has been done on the effects of social class on the perception of life events. Some studies report no relationship between class and life changes, while others report that the persons of the lower class have a greater number of life events.

There are several concerns in using a life events questionnaire or check list. First, there is the concern on whether the events are truly stressful. Second, the methodology of assigning a numerical value to each event. Third, the length of time within which it is assumed that the event or experience continues to create stress within the individual. Fourth, the effect of life events on various subgroups. Fifth, to what degree positive life events compare with negative life events in creating stress.

There are two other approaches currently utilized in measuring life stressors: (a) the measurement of daily Hassles and Uplifts (Kanner, Coyne, Schaefer, & Lazarus, 1981) and (b) the measurement of the social environment or stimuli (Moos & Moos, 1981).

Assessment of Coping Responses

Coping responses are mediators between the stressor and the stress response. Cognitive coping responses can include an attempt to (a) manage the appraisal of the stressful event, (b) avoid facing the problem, (c) manage the emotional consequences of the stressors (Billings & Moos, 1981).

Billings and Moos (1981) have separated the coping response into two categories. The first category addressed the mode of coping. This included active cognitive, active behavioral, and avoidance approaches. The second category addressed the focus of coping. This can be either problem or emotion centered. In this mode of assessment, respondents were asked to reflect on a stressful experience. The respondents were then given statements, and asked to indicate their method of coping.

In an analysis of a survey sent to 360 families in the San Francisco Bay Area, it was discovered that women had greater frequencies of active-behavioral, avoidance and emotion focused strategies. There was a positive correlation between persons of high income and their use of active behavioral, active cognitive, and problem focused coping. There was no significant correlation between the intensity of the stressor and the coping mechanism.

Assessment of the Stress Response

Stress response is measured using physiological, behavioral, or cognitive measures. Here the response is considered an independent variable, and thus lends itself to a greater variety of measures than that of measuring stressors.

Physiological Measures. There are two modalities in measuring physiological responses. The modalities are the biochemical and the psychophysiological.

In measuring the biochemical responses, it should be noted that the central nervous system, immune, catecholamine, hypothalamico-pituitary-adrenocortical, sympatho-adrenomedulary, and endorphin-enkephalin systems are all involved in the stress response (Baum, Grunberg, & Singer, 1982; McCabe & Schneiderman, 1984). It is possible to obtain blood samples and analyze the levels of hormones to study the stress response. In reviewing the research done on stress and the immune system McCabe & Schneiderman (1984) reported that stress increases the steroid hormones which then tend to suppress the immune system. This leaves the individual more susceptible to infections. Feuerstein et al. (1986) stated, "Physiological markers of stress cannot be used as the sole indicators of the stress response; they measure only one aspect of the stressor-stress response and may be sensitive to other factors as well" (p. 117).

Psychophysiological responses are also a part of the stress response. In measuring the stress response, muscle activity, blood pressure, heart rate, and

electrodermal responses are recorded. Hypertension and pain disorders have been correlated with the stress response. However, much more research needs to be done to define the relationship between the psychophysiological responses and the various components of the stress response. (Fuerestein et al., 1986)

Assessment of the Behavioral Response

There are two modes in assessing behavioral response: direct observation and self reports.

Observation. There are two observational methods. The first method records behaviors such as facial expressions and speech rates. However, the choice of what behaviors to record and the issues of observer bias and the assessment techniques are major concerns. (Kent & Foster, 1977) The second method of observation focuses on the performance ability of the subjects. Tasks such as problem solving, memory, and visual motor skills, are helpful in stress assessment. In experiencing various levels of stress, changes tend to occur in the level of performance abilities. Thus, performance tasks can be used to distinguish between persons who do and do not experience stress, when exposed to various stimuli.

Self Report Measures. These measures such as questionnaires and check lists, are used to provide information on behavior that may not be observed in an experimental setting, or to provide additional behavior. These

self reports usually focus on behaviors such as urination frequency, nail biting, or the avoidance of certain stressors.

Assessment of Cognitive Measures

Beliefs, attitudes, and moods are some variables analyzed in assessing the cognitive component of stress. These cognitive responses measure not only the stress response, but also measure the appraisal performance of the individual. Fuerstein et al. (1986) in describing these instruments stated

> Of particular relevance to the measurement of the cognitive component of the stress response is an assessment of perceived control, mood, and perceived autonomic arousal. A survey of the research literature shows that these concepts are often examined, relative to behavioral and physiological variables that may be associated with stress, health, and disease. (p.119)

Miller (1978) stated that cognitive or perceived control usually reduced the stress response. Averil (1973) noted that there are two components to cognitive control. First, there is the information gained by which one can predict the stressor. Second, the individual can prepare, interpret, and evaluate the event.

Instruments

Four instruments were used to measure the various outcome variables. The Strain Questionnaire (SQ) measured the reported levels of stress inducing cognitions and physical symptoms. The Family Adaptability and Cohesion Evaluation Scales (FACES) measured the reported levels of adaptability.

The Parenting Stress Index (PSI) measured the parenting sense of competence. The Beck Depression Inventory (BDI) measured the levels of depression.

The Parenting Stress Index

The PSI was developed by Richard Abdin to measure the degree of stress in the parent child subsystem. The instrument is one of the most widely used instruments that measures the degree of stress in the parental subsystem. Lafferty (1980) used the PSI to measure the effect of parent education on the levels of stress experienced by parents. Pre and post measures were taken for two groups of parents who had come for parent education training. There was a significant difference in the parent domain score, child domain score, and total stress score because of the training.

Plough (1980) studied the efficacy of brief consultation (1-8 sessions) for mothers of children up to the age of ten, who were experiencing parenting difficulties. She found a significant reduction in the Total stress score after consultation. Abdin (1986) stated that "The Plough and Lafferty studies suggest that the PSI is sensitive to reduction in stress level as a result of psychological intervention, and therefore may be a valid measure of intervention effectiveness" (p. 21).

The Family Adaptability and Cohesion Evaluation Scales

This instrument measures the degree of cohesion and adaptability within the family system. Garbarino, Sebes, and Schellenbach (1985) used FACES to

compare 27 high risk families with 35 low risk families. The authors focussed on the levels of stress and conflict and parenting styles in those families. It was found that the majority of low risk families had balanced scores, and the high risk families had extreme scores on FACES.

The Strain Questionnaire

The Strain Questionnaire is a self report instrument which measures the cognitive, behavioral, and physical symptoms responses to stressors. The questionnaire was normed on a sample of 412 persons which consisted of undergraduate students, insurance agents, school teachers, and naval engineers. The reliability results ranged from .62 to .88. The instrument also has concurrent validity with the Beck Depression Inventory.

The Beck Depression Inventory

This 21-item instrument is one of the most used instruments for measuring the degree of depression in clinical patients and for detecting the possible existence of depression in nonpatient populations. The instrument measures both cognitive and somatic symptoms of depression. The BDI has been normed on populations with personality disorders, major depressions, dysthymia, and substance dependence diagnoses (Beck & Steer, 1987).

Maternal Stress and Family Functioning

Khoe (1986) reviewed the literature on the psychosocial adjustment, cognitive development, academic performance, and sex role development of

children of one-parent homes. He found the following to be critical factors in the determination of the children's adjustment: (a) the age of the child since the divorce, (b) length of time elapsed since the divorce, (c) parental stress, (d) parental conflict, and (e) the quality of the parent-child relationship.

Crnic, and Grenberg (1990) investigated the relationship between parenting stresses and its impact on children. Seventy four mothers and their 5-year-old children were studied. It was found that daily hassles and life stresses were significant predictors of the general well being of the children and family.

Child Abuse

Tableman (1982) noted that the risk of physical and sexual abuse and the neglect of infants have increased among working female heads of households. The Schedule of Recent Experience was administered to 35 parents who had abused their children and to 35 parents who lacked a record of abuse, but had difficulties in executing the parental role. The results suggested that much higher life change scores were obtained with the abusing parents (Justice & Justice, 1982). Wolfe (1985) reviewed various studies to ascertain the variables that distinguish between abusive and nonabusive parents. The indications are that abusers tended to report greater levels of stress symptoms such as depression and various health problems.

Mother-child Interaction

Crinic (1983) studied 52 mothers of premature infants and 53 mothers of full-term infants. The behavioral interactions between mother and infant were recorded at one and four month intervals. The level of parenting satisfaction and maternal life stress were assessed at the one month visit. Results indicated that both the level of maternal support and stress experienced by the mothers significantly predicted the maternal attitudes at the one month visit and the level and quality of interactive behavior at the fourth month visit. The mothers whose profile indicated greater levels of stress tended to be less positive in their attitudes and behavior. There was a strong positive correlation between the level of maternal social support and the infant interactive behavior.

There are several studies that measure family functioning post divorce. However, there are relatively few longitudinal studies that measure the home environment, parent-child interaction, parent's child rearing orientations, and parents' self descriptions before divorce and then post divorce. Morrison (1983) studied two parent families whose children were three years old. He then assessed the families when the children were 4, 6, and 12 years old. The results indicated that before the divorce, mothers tended to be unavailable emotionally and physically for their children and were more involved with their careers and activities. After a divorce, the economic pressures and the competing demands of the family and a career, tended to further depress the quality of life for children in single parent homes.

Belle, Longfellow, and Makosky (1982) studied the impact of maternal stress and depression on the parent-child relationship. The sample consisted of 43 low income urban mothers. Twenty were single parent heads of households. Maternal behavior was examined in the following areas: nurturant; prosocial; dominant interactions with children; use of friendly affiliative, hostile-dominating, positive or negative response styles; and compliance with the dependency bids of the children. Mothers who were experiencing stress and depression found it difficult to be nurturing and responsive to their children.

Taylor, Underwood, Thomas, and Ahang (1990) studied the effects of dysphoria on maternal exchanges. Forty families were enrolled in a treatment and prevention program for high risk families for neglect and child abuse. It was found that there was a significant negative relationship between the level of maternal dysphoria and the parent to child relationship.

A review of the theoretical and empirical literature on mothers who ranged from depressed mood to clinical depression was done. It was found that depression correlated with unhealthy parenting practices. Such practices included inattention and inept discipline. Child psychopathology tended to accompany maternal depression.

In researching the behavior problems in middle childhood, a study of 159 children whose ages ranged from 6 to 9 was conducted. Thirty five family members had experienced the stress of divorce at least four years prior to the

study. A strong relationship was found between behavior symptoms and stress (Wertlieb, Wiegel, & Fieldstein, 1987).

Academic Performance

The impact of stress in single parent families on the academic functioning of children has also been documented. Wyman, Cowen, and Hightower (1985) compared 98 nine-to-twelve year olds from divorced families with 170 children from intact families. The children of divorced parents experienced higher levels of anxiety and had lower academic competence, as measured by the Perceived Competence Scale for Children and The State-Trait Anxiety Inventory for Children respectively.

Felner, Ginter, Boike, and Cowen (1981) in studying the effects of stress on academic performance studied primary school children. The first group consisted of urban children referred for academic and discipline problems. Sixty four students came from divorced homes, 21 students had deceased parents, and 90 students served as the control. The second group consisted of unreferred rural children. There were 37 from divorced homes, 14 had deceased parents, and 51 served as controls. The students completed the Classroom Adjustment Rating Scale and the Health Resources Inventory. The results suggested that students with a deceased parent tended to be shy. Students from divorced homes had a greater number of behavioral problems and fewer academic competencies than the other groups. These patterns were

consistent over the urban and rural samples and the referred and nonreferred groups.

Robbins, Dunlap, and Anthony (1991) studied the progress of 12 children between the ages of 29 to 52 months for a period of one year. These students were moderate to severely cognitively impaired. Measures of the mothers and children were taken at intake. There was a strong relationship between the level of maternal stress and child progress as was measured on the Learning Accomplishment Profile.

Social Support and Children

The lack of social support has a negative impact on single parents and their children. Colletta (1979), in researching the impact of support systems on post divorced functioning, examined 72 working class mothers. The divorced and married mothers differed in the amount and sources of social support they received. The amount of support received and the mothers' satisfaction with that support, was significantly related to a number of child rearing practices. The results tend to indicate that families under extreme stress need to be provided with somewhat high levels of support, or the dissatisfaction with their support systems will appear in harsher and more restrictive relationships with their children.

The effects of maternal stress and social support on the mother-infant relationship has been noted by Crinic, Greenberg, Robinson, and Ragozin (1984). Sixty-nine mother-child relationships were studied longitudinally.

Parenting satisfaction, life satisfaction, and the social support of the mothers were measured when the infants were 1, 8, and 18 months. The interactions between the dyads were assessed at 4, 8, and 12 months. The results indicated that the level of stress and social support predicted the maternal attitudes and dyadic relationship. However, at 18 months the predictive power of stress and social support was not as great compared to the earlier months.

Adamakos, Ryan, Ullman, and Pascoe (1986) studied the use of the level of maternal support in predicting the level of mother-child stress, and the level of stimulation provided by the mother to the child. Thirty-eight low income mothers and their two year old children were studied. The level of social support experienced by the mothers was measured prenatally and then two years later. The findings indicated that the level of maternal social support correlated negatively with the level of stress in the mother-child dyad and positively with the level of stimulation. It was also discovered that the level of support was the best predictor of the levels of stress and stimulation in the parent-child relationship.

Sibling Interactions

Maternal stress affects not only the mother-child interaction, but also sibling interactions. Mash and Johnston (1983) observed 46 normal and hyperactive boys engaged in mother supervised tasks and in unstructured play with siblings. The mothers' level of stress and self-esteem were measured by the Parent Stress Index and the Parenting Sense of Competence Scale,

respectively. Higher levels of sibling interactions during play occurred with the children of parents who had high levels of self-esteem and low levels of stress. Negative behaviors during the mother-supervised task was also very strongly correlated with the mothers' level of stress.

Adolescence

Erickson (1968) described adolescence as a period of crisis. He defined crisis as "a necessary turning point, a crucial moment when development must move one way or another, marshalling resources of growth, recovery, and further differentiation" (p. 15). This crisis can be recognized and understood from a systems perspective. Robin and Foster (1989) in describing this perspective wrote

> Adolescence is a period of exponential physiological, cognitive, emotional and behavioral change. . . . These psychosocial changes can be examined in terms of the adolescent's developmental tasks, the major one of which involves becoming independent from parents. Prior to the adolescence of its young members, a family has established self-maintained and self-maintaining patterns of mutual influence over each other's behavior. The independence-seeking behavior of young teenagers interrupts these previously established homeostatic patterns of family relations. The system reacts to these changes by attempting to reestablish control and balance. Some conflict is normal during this time of adjustment. The manner in which families react to the challenges of teenage individuation determines whether the normal perturbation of early adolescence is resolved or whether it escalates to clinically significant proportions. (p. 8)

The period of adolescence is thus a very stressful one for families. Stress occurs because of the one-parent role overload, and second, it is generated as the family has to respond to the changes caused in the family system by the adolescents.

Pasley and Gecas (1984) have documented the stresses which parents experience in parenting adolescents. In reviewing the literature on parenting roles and parenting satisfaction throughout the family life cycle, 149 mothers and 136 fathers were questioned. Parents reported that the best stage in parenting occurred between infancy and five years of age. The most difficult was during adolescence. The issues of independence and lack of control were recurring themes.

Many female heads of households have to work, and many often hold two jobs to support their family. The effect of maternal employment on adolescent daughters is very revealing. Jensen and Borges (1986) had 53 female undergraduates who, when they were adolescents, had both parents living at home. The undergraduates were asked to respond to issues on stress and anger in the home. Results indicated that where the mothers were unemployed, the adolescent girls had a closer relationship with their father, and that there was less tension and anger within the family structure.

Wiersin, Armistead, Forehand, and Thomas (1990) investigated adolescent conflict and stress as a parent. The parents of 60 and 62 adolescents between the ages of 11-14 were studied to determine if there was any difference in the levels of stress and competence based on the gender of the parent. It was found that there was no difference on the variables of depression and parenting competence. However, mothers did report much

greater levels of stress and parent adolescent conflicts. Mothers also reported a lesser positive relationship than did the fathers in the study.

Young Adulthood

The impact of divorce or single parenting is also seen in early adulthood. Fry and Trifiletta (1983) in a study of 150 adolescents of single parent homes, found that there were four major stress-causing clusters: (a) family conflict and distress, (b) parents' affective state, (c) adolescent disharmony, and (d) parent-adolescent role reversal. Cooney, Smyer, Hagestad, and Klock (1986) interviewed 18 male and female undergraduates whose parents had been divorced within three years in order to discover any effects on the young adults. It was noted that for many young adults, the parent-child relationship remained very firm. However, the most vulnerable relationship was that of the father and daughter.

While many single female parents do struggle valiantly to overcome the extra-familial sources of stress, they also have to contend with the stress created by the perceptions and behaviors of their children. Parish and Osterberg (1985) examined the role of family structure and the stress experienced by 164 undergraduate students. The students came from single and two-parent homes. Students consistently gave fathers higher positive evaluations. Single female parents received the most negative evaluation of the four parent groups.

Components of Stress and its Management

The stress and disruption that female headsed households face can be overwhelming. Some problems include economic hardship, role overload, social isolation, job discrimination, feeling of loss and grief, parental control, relationship with the non-custodial parent, lack of managerial skill and time management (Bray, 1982; Buehler & Hogan 1980). The above factors can lead single female parents to experience depression, various physical symptoms, high levels of adaptability in the family system, stress inducing cognitions, and a loss of self competence.

Occupational Factors

Beck (1984) indicated that many single parents besides dealing with grief and loss from death or divorce, also have the additional difficulties of being heads of household. Thus, even the most resilient of women have great difficulty in preventing stress-related illness. There is, therefore, a need for a shorter work week and increased leisure time for these parents. In reviewing developmental and family psychology, Lewis (1983) suggested that employed mothers may find employment to be beneficial when there is a good role fit. Kelly (1985), in observing the work and family role strain, measured three variables that could contribute to job tension. They were family-level, individual-level, and work related. Work related variables tend to have the greatest impact on job tension. The greatest impact occurred with female single parents.

Burden (1986) also found in examining multiple job and home life responsibilities, that of various parent employees, single female parents were at the highest risk for family-job strain, and experienced the lowest levels of well being. In spite of the added stress, single female parents lacked higher rates of absenteeism, and indicated that there was a high degree of job satisfaction. The displaced home makers, especially those who are middle aged and attempt to return to work, have the added stresses of lack of prior work experience, and adapting to the work setting (Balding & DeBlassie, 1983).

Financial Factors

The impact of low financial income for single parents is well known. Colletta (1983) surveyed 48 divorced and 24 married mothers at income levels of $12,000 and $6,000. Data from that survey indicated that income, more than absence of a father, was the main source of stress. The low income single parents experienced the greatest degree of stress. The economic plight of female heads of households is becoming more bleak. Thus these households continue to experience greater levels of stress in their family interaction.

Many female heads of households experience enormous economic difficulties. The U.S. Bureau of the Census (1987) indicated that the median income in 1986 for a married couple whose wife was not in the paid labor force was $25,803. The median income for a female householder with no spouse was $13,647. In 1986 11.0% of all families and 34.6% of all families headed by women were within the poverty level.

In 1989 the median income for a married couple whose wife was not in the paid labor force was $28,747. The median income for a female householder with no spouse was $16,442. The poverty rate for all families with children below 18 years of age was 20.6%. The poverty rate for the female heads of household with children below the age of 18 was 51.2%. The poverty rate for female heads of households with children below the age 6 years was 61.4% (U.S. Bureau of the Census, 1991).

Relational Factors

Single female parents, especially those who have been divorced or separated, usually experience severe disruption in their personal life. This disruption is often accompanied with emotional trauma, physical and mental illness (Dyer, 1986). McLanahan (1985) posited various hypotheses to explain the fact that single female parents tend to have more psychological distress than the rest of the adult population. Interview data over a four-year period from 6,331 fathers and 2,152 single mothers were analyzed. The longitudinal data confirmed that single motherhood caused a decline in the psychological well-being, and that chronic strain and changes in life events caused great psychological distress. However, the high level of change of events is due to the disruption of the marriage bond, and not the estate of being single.

Garidubaldi, Cleminshaw, and Perry (1985) examined the physical and mental health of parents from divorced and nondivorced families, in terms of parent satisfaction. Analyses of variance showed that the health of parents

from divorced families was lower that those from nondivorced families. Multiple regression analyses indicated interdependence among divorce, mental, physical health status, and stress.

Much has been asked concerning the effects of stress on married versus single, and male versus female parents. Wood (1977) found that among married persons, women have a higher rate of mental illness. One hypothesis advanced for this is the stress factor. However, married women have less mental and physical illnesses than the never married, widowed, or divorced women. Married men report lower rates of illness than single men.

Tcheng-Laroche and Prince (1983) interviewed separated, divorced, and married mothers. They found that separated and divorced mothers were worse off in terms of sexual satisfaction, life satisfaction, self-esteem, and on almost all other health-stress measures. There were no trends favoring the single mothers.

Herman (1977) in interviews with a sample of 200 women noted the feelings of hopelessness and depression that reside within those persons. This stress is compounded by the fact that many of these women do not have the role development to be integrated into the political, social, or economic structures of society. Another factor that intensifies this stress is the difficulty that many women have in adopting new roles to reflect their new status. Women are socialized to be passive and have been placed in this dilemma

which is very difficult to resolve. Thus, there are feelings of desperation, and thus suicide attempts.

Depression

Jones and Gray (1984) surveyed therapists who worked with Black patients and found that mood disorders such as depression were the most frequent diagnoses. The most frequent presenting complaints of Black women were depression and family problems. Russo and Olmedo (1983) in a study of outpatient psychiatric services found that depression was the leading diagnosis for women. The rate for Black women was 42% higher than that for White women.

Wetzel (1984) indicated that the symptoms of depression can be divided into four areas: affective, cognitive, physical, and behavioral. In the affective area "depression ranges on a continuum from mild blues common to the human condition to severe despair" (p. 7). Persons who are depressed tend to experience anxiety, guilt, and resentment. In the cognitive area people have difficulty with concentration and decision making. Behaviorally, persons tend to withdraw and become nonassertive. Physically, persons may experience disturbances with their sleep, appetite, and sexual functioning.

McGrath, Keita, Strickland, and Russo (1990) indicated that there are 7 million women in the United Stated with diagnosable depression, and that many of these women will never be treated for the depression. In a discussion of the risk factors for depression, McGrath et al (1990) concluded: (a) women are at

higher risk because of economic, social, biological, and emotional factors; (b) women's depression relate to cognitive and personality styles such as avoidance, negative cognitive styles, and focusing on the depression rather than attaining mastery strategies; (c) mothers who have young children are at a higher risk of experiencing depression, and the level of depression increases with the number of children at home; (d) poverty is a "pathway to depression," and that 75% of the poverty population are women and children.

Women tend to experience depression at a higher rate than men. Kessler, Mcleod, and Wethington (1985) showed that in the process of coping with the stresses of life, many women develop a depressive syndrome in reaction to stressors. Newman (1986) indicated that women experienced a higher rate of depression due to the fact that they experienced stressors such as lack of social support, financial problems, and health problems. The multiple roles which women are called upon to perform increase their levels of stress, and thus increase their risk of depression (Belle, 1982). McGrath et al. (1990) stated "Given women's over representation among informal support providers and confidants, it is hardly surprising that women suffer more than men from the 'contagion of stress' that is felt when disturbing life events afflict those to whom we are close" (p. 22).

In the discussion on various treatment modalities, McGrath et al. (1990) asserted:

> Cognitive-behavioral therapy offers management techniques which fit recommendations from some of the latest depression research

> such as the value of distraction, mastery, and action strategies in alleviating depressive symptoms in women. For example, understanding and identifying cognitive distortions and negative thinking and developing behavioral skills to move more quickly into action and problem solving modalities may help women counteract earlier conditioning towards passivity and helplessness. (p. xiii)

Health Outcomes

Seyle (1950) in his concept of the General Adaptation Syndrome focussed on the response of the body to the various demands placed upon it. Since then, various researchers and theorists have focused on the impact of stress and coping on health outcomes. There is still much debate as to the specific relationship between stress, coping, and health outcomes. Lazarus and Folkman (1984) stated

> By and large, we accept the premise that stress, emotion, and coping are causally tied to illness, although evidence is less clear and less fully spelled out than is generally realized. Most people working within psychosomatic medicine, behavioral medicine, health psychology, and related fields also accept this premise to a greater or lesser degree. . . . A review of research on psychosocial factors and susceptibility to infectious disease by Jemmott and Locke (1984) presents a fairly strong empirical case that this premise is sound, at least with respect to the mediating role played by immune competency in the stress-infection relationship. (p. 205)

In an attempt to identify the degree to which an individual is able to cope with stressors and mediate the effect of stressors in inducing physical illness, Kobasa (1979) introduced the construct of hardiness. Hardiness defines the degree to which individuals can cope with the stress in their lives and remain physically healthy. Hardiness measures three personality characteristics: (a)

commitment to life's activities, (b) control over life's events, and (c) accepting change as a challenge rather than a threat (Kobassa, 1979, Lazarus & Folkman, 1984).

Various studies have focussed on the relationships between hardiness and health. Some of the physical symptoms associated with stress include muscle tension, dizziness, headaches, stomach aches, heart palpations, insomnia, and breathing difficulties. Weisman and Worden (1975) demonstrated that patients who were depressed and alienated had a shorter survival rate than those who used social support. Harburg, Blakelock, and Roeper (1979) studied the effects of anger on hypertension. Subjects were questioned as to what their response would be to an angry boss. Their coping responses were classified as (a) "anger in," where they would walk away from the situation; (b) "anger out," in which they would protest to the boss; (c) "reflective," where they would talk to the boss after he had cooled down. During the interview the blood pressure was taken several times. The results indicated that those persons who engaged in a "reflective" coping style had lower blood pressure readings.

In summarizing the effect of coping on physical illness, Lazarus and Folkman (1984) asserted the following: (a) "coping can influence the frequency, intensity, duration, and patterning of neurochemical stress reactions" (p. 215); (b) coping affects health negatively when it resorts to the excessive use of substances such as drugs, alcohol, and tobacco; (c) coping that is emotion-

focussed has the ability to intensify physical sickness, by restricting the adaptive behavior that could promote and maintain health. It is therefore important to provide persons with healthy coping strategies in order to reduce the levels of physical illness.

Eysenck (1983) maintained that over the years various health professionals hypothesized on the relationship between stress and illness. In discussion on the subject he stated

> There is, to begin with, the distinction between chronic and acute stress; there is, secondly, the distinction between avoidable and unavoidable stress; and there is, thirdly, the problem of coping mechanisms. In relation to the disease itself, we cannot just talk about "cancer", but must deal with the several phases involved, i.e. tumor induction, tumor growth, and metastases. (p. 126)

Several studies (Bloom, Asher, and White, 1978; LeShan, 1966) show that in situations where persons have experienced the stressor of loss of a spouse, the frequency rate of cancer was much higher than in the general population.

Family Adaptability

Burr (1973) indicated that Angell (1936) was the first person to carry out a systematic analysis on the abilities of families to recover from crisis and stress. Angell (1936) studied the economic depression in the 1930s and postulated that integration and adaptability were the two major variables which aided in the recovery process. He defined adaptability as the ability of the family to change its structure without much organizational discomfort. Hansen (1965) expanded further on Angell's concepts to include integration and adaptability as variables which can prevent stress from creating crisis. Hill

(1949) found that when the level of crisis was held constant, families who were less organized or had high levels of adaptability experienced more severe crises, or were more vulnerable to stress.

Olson and McCubbin (1982) developed the "Circumplex Model" of marital and family functioning. They identified two constructs of cohesion and adaptability as important concepts in the understanding of family stress theory. They defined family adaptability as "the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and development stress" (p. 51). There are four levels of adaptability. At the low end of the spectrum are families who are very rigid; at the low to moderate level the families are structured; at the moderate to high level the families are flexible; and at the high end of the spectrum the families are very chaotic. Olson and McCubbin (1982) hypothesized that families who operate at the central levels of being structured and flexible will demonstrate healthy approaches when they face situational stresses and life changes.

Stress Inducing Cognitions

Wetzel (1984) examined maternal and homemaker roles in society and noted that these roles are not very highly valued. Women are socialized to please others: thus, they tend to deny or fully attend to their needs. This places women in a dependent status on others for them to feel fulfilled or happy. Thus, women tend to have negative cognitions of themselves. Wetzel (1984) stated, "Their inferior position in society leads them to perceive of

themselves in the same guilty manner. Self-deprecation, unfavorable comparison, distrust of self, and perceptions that others negate them are all extensions of the culturally reinforced negative cognitions of women" (p. 185). Zajonc (1980) delineated two types of cognitions and their relationship to stress. Hot cognitions are those to which affect is attached and can induce stress. Cold cognitions have very little affect attached to them.

Hamilton (1984), in using an information processing model, reported cognitive stressors as "those cognitive events, processes, or operations that exceed a subjective and individualized level of average processing capacity" (p. 109). He further defined cognitions as a behavior which is involved in knowing. This knowing is as a result of the information that individuals have stored about themselves and their external environment, and how they interact in pursuit of their goals. The behavior involved in knowing depends on the information-carrying structures of the cortex, and is referred to as long term memory. These memory structures contain the experiences generated, by external signals as well as those which have been internally generated such as fantasy or day dreaming. The process utilized to meet various demands is the short term memory. Stressors can be regarded as aversive stimuli presented to the cognitive processing system, while the system is engaged in other tasks. This creates an overload on the cognitive system. This load on the system is increased when there is an insufficient level of coping strategies.

Parenting Sense of Competence

Kessler and McLeod (1984) asserted that it is the unhealthy coping strategies of women due to gender socialization which render them at greater risk to stress. Warren and McEachren (1983) concluded that low levels of perception of life control in women is related to higher levels of stress and depression.

Lazarus and Folkman (1984), reviewed the theory of learned helplessness, and stated that the origins of this theory occurred in the laboratory. Animals failed to avoid an electric shock, even when they could have jumped to safety. A cognitive interpretation of this behavior would suggest that the animals through prior conditioning had learned that they were helpless in the face of the surge of electric shocks. The theory of learned helplessness has gone through many revisions. Abramson, Metalsky, and Alloy (1989) have revised their 1978 theory, and now focus on the expectation of hopelessness as a cause for hopeless depression. In this model, helplessness expectancies and negative outcome expectancies lead to a sense of lack of competence.

Emery (1988) reviewed various therapeutic approaches to enable women to increase their level of self competence. He concluded that the cognitive-behavioral approach facilitated women to gain control over their cognitions, and thus realized a sense of power and mastery over their lives.

McGrath et al. (1990) addressed the use of the cognitive-behavioral approach in developing a sense of competence among women. They indicated that the first cluster of symptoms to be targeted is the emotional. Thus, women are helped to recognize that the feelings of guilt, sadness, and anxiety are not created by themselves, but stem from individuals' thoughts. People can be made to think differently by questioning the validity of their negative thoughts. The second cluster of thoughts are behavioral. Here behaviors such as withdrawal, nonassertiveness, and a lack of pleasurable activities are targeted. Women are enabled to increase their sense of competence by having them engage in tasks that they previously considered too difficult or impossible to perform. As the women conduct the tasks, they are encouraged to assess whether their thoughts on the tasks were true.

If single parents are to decrease their level of stress, then they need to increase their sense of competence. The theoretical model of stress on which this study is based is the Interactional Model. This approach recognizes the stressor, stress response, and the individual's active involvement in the stress process. Thus, in the EAR approach, emphasis is placed on issues of coping, appraisal, hardiness, and a sense of competence. The sense of competence variable is measured by the Parenting Stress Index. The sense of competence of the participants is enhanced by cognitive restructuring, boundary delineation, self-reinforcement, role play, appraisal, and empowerment. In cognitive restructuring, the participants will be aided in identifying and altering their

irrational beliefs and negative self statements. In boundary delineation participants will be shown how to set parameters in terms of stressors due to time, cognitions, and behaviors. In self-reinforcement training, participants will learn to describe themselves in a positive manner. The above techniques should aid in increasing the sense of competence of the single female parents.

Support Systems

If parenting is to be conceptualized as a growth process, and high degrees of stress mitigate effective parenting practices, then it is imperative that society provides networks of support for single female parents. Hulse and Sours (1984) support the view of multiple mentoring techniques. Single mothers are offered opportunities for networking as their employment and academic goals are realized. The mentoring process provides stress management, personal finance, career plans, and the sharing of personal experiences. Single parent groups focus on personal growth, problem solving and coping skills. McLanahan, Sara, Wedemeyer, and Adelberg (1981) researched the family of origin, conjugal, and extended supporting networks available to single parent families. In a study of 45 single mothers, they found that the role orientation of the mother, mediated the effects of the network structure and social support on the emotional and psychological states of the mothers.

Woody, Colley, Scheduling and Magann (1984) examined parental stress and adjustment to divorce in relation to background data, stress and symptoms.

Results showed that crisis level stress was related to the recency of the divorce, but that the use of a supportive system predicted lower scores.

McAdoo (1982) examined Black families and their utilization of support systems. She noted that Black families did not have a propensity to seek support systems from outside their family network. Many Black families believed that social service agencies were unsympathetic to the stressors they faced. Thus, external help was only sought if familial resources were depleted, or no solution or consensus obtained from within the extended family structure. Thus in Black family organization, both the nuclear and extended families play a great role in absorbing the stress experienced at the systemic level.

In discussing single Black female heads of household and support systems, McAdoo (1982) reported

> In the present study their incomes were lower and they had no choice about working. They did not have another person with whom to share the child rearing tasks, and they experienced greater stress. Those with the greatest needs had the fewest resources. Their supportive needs would likely be greater and would require the family and community programs to absorb more of their stress. In a period of changing priorities and economic instability, they will likely find it more difficult to gather the needed resources from outside the family. (p. 486)

Hynes (1979) studied the relationships between social and psychological factors and distress in low income single parent mothers. The sample of 95 included 63 Blacks and 32 Whites. These mothers either lived in subsidized public housing or received Aid to Dependent Children. A multivariate correlational analysis was executed to study the relationship between social supports and locus of control. The results indicated that (a) where single

mothers utilized social supports, whether they were informal, natural, or familial, there was lower distress; however the use of societal resources such as community agencies had a weak association with lower distress; (b) greater financial independence is not related to lower stress; however, parents with lower incomes, regardless of origin, report higher distress; and (c) lowered lingering attachments is strongly related to lower stress.

The Need for Stress Management Programs

The need for stress management training programs such as the one conducted in this study is amply borne in literature. Quinn and Allen (1987) asserted that the female-headed family is a structure that presents challenges to family life educators, family counselors, and policy makers. Thus, for effective delivery of services, accurate information on the functioning of these families is needed. In a study designed to examine the challenges faced by female single parents, the authors examined 30 women between the ages of 25 and 38 years who were employed for at least 30 hours weekly, had two or more children living at home, and lacked other adults living in the house. During the interviews, the women talked about their lives, families, concerns, strengths, and how they visualized themselves in the next 10 years. The single parents had major concerns about finances, time, and child care. They felt that neither their education nor their socialization had prepared them for the lives they were living.

Quist-Pena and Richarz (1986) in an attempt to improve the content of parent education programs, investigated the interest and needs of female single parents. The participants were 66 single female custodial parents between the ages of 20 and 44, and had children 7 years of age or younger. A 47-item questionnaire explored (a) topics for education programs, (b) the support the program could offer, (c) factors influencing participation, (d) methods of information presentation, and (e) demographic variables. The results indicated that the mothers were interested in receiving instruction on several topics, including the understanding of the children's emotional needs, effective disciplining techniques, methods of increasing effective communication, the process of learning how to deal with difficult issues, and ways to obtain high quality child care. The mother's interest in support services centered on programs offering recreational or stress relieving activities and opportunities to locate male role models for their children.

Goldman (1984) contended that society must begin to see parenting as a growth process. Parents do not have the answers just because they are parents. Instead knowledgeable persons in the society should be providing insights into the process of parenting. Support systems should be built that would lessen the degree of stress and conflict and reduce the cycles of abuse and adult violence.

In discussing the need for relevant policy recommendations for single heads of households, Mednick (1987) realized a distinctive shift in viewing

single parenting as something pathological. Current research focuses on the on the adjustment and well being of the parents. Emphasis is now placed on the issues of social support networks, coping skills, and social conditions.

Weissman, Leaf, and Bruce (1987) in a community study on single female parenting, compared the economic, psychiatric, and social functioning of single and married women between the ages of 18 to 44. It was found that both groups were similar in their levels of psychiatric and social functioning. The authors concluded that the problems encountered by many female heads of households may be due to poverty and stress.

Stress Management Programs

Several stress management programs have been developed over the years. The following is a review of some issues and the effectiveness of various programs.

Issues in Designing Programs

Rayburn (1986), in discussing the therapeutic implications of stress among women, recommended that the following issues should be addressed: social support groups, time and stress management, adequate rest, physical exercise, recreation, job enrichment, continuing education programs, child care, assertiveness training, and consciousness raising. Women must be viewed as innately worthy persons, and they need to know that their opinions, thoughts, and feelings will be taken seriously and treated with respect and concern.

Another issue in formulating stress management programs concerns leadership. It is very important that the leaders like women, be empathic, and have the capability to share themselves in the group (Marciniak, 1984).

Schwebel (1982), in discussing programs for single parents, indicated that the involvement of both parents in the child rearing process and mediation between the ex-spouses tend to reduce the levels of stress experienced by divorced families. Programs should focus on the development of communication skills, contingency management, and the behavioral application of modeling and behavioral rehearsal. Lutzer (1987) suggested that in the development of programs, mothers should be made aware of normal developmental stages of childhood and adolescence. This knowledge would aid in mitigating the needless stress that mothers experience when a normal stage of child development is assumed to represent abnormal behavior.

Railings, and Carter (1979) posited that loneliness and autonomy are major issues that should be addressed when working with single women. In working with these women, therapists need to go beyond the intra-dynamics of stress and provide some basic information on legal issues and on the various resources and support groups available within the community.

Richard (1982), in defining issues faced by single female parents, suggested that it is important for persons who work with these parents to be cognizant of the impact of economic status on various intra-and inter-personal problems. It is also important to realize that the emotional challenges of single

male parents differ from those of single female parents. Issues that need to be addressed in working with single parents include loss, trust, stress factors, development of coping skills, communication, and the ability to focus on salient issues that relate to their physical and emotional well being.

Jones (1984) focused on the issues of emotional and organizational adjustment of working single mothers. Issues such as child care and sibling supervision; time, household and social life management were also discussed.

LaPoint (1977) administered a questionnaire to ascertain the needs, concerns, and perceptions of Black female single parent families. Some of the concerns included inadequate finances, transportation, housing and food. There were other concerns such as the quality of parenting, discrimination in obtaining credit, the experience of negative attitudes and practices of society towards single parent families, performance of tasks that are usually done in two parent families, and loneliness.

The single parents reported various positive aspects of their family life. These included the emotional and physical support given by the children, strong family interaction, the ability to adapt to a single parent family lifestyle, and the role of religion in strengthening the family bond.

Effectiveness of Programs

Tableman, Feis, Marciniak, and Howard (1985) conducted two experiments to examine the effectiveness of stress management training (SMT), as a prevention model and as a treatment program for low income women. SMT was developed as a multidimensional program to provide an introduction to life-coping skills and a means of helping women feel better about themselves. The program also helped the women take more control, accept responsibility, and learn how to handle stress. Experiment 1 examined whether SMT improved the capacity of low income women to handle stress. Experiment 2 compared SMT with traditional individual outpatient therapy on certain outcome measures. Results revealed that the trained subjects were in better mood stated and reported a greater perception of control than the women who did not receive SMT training. Services for SMT participants tend to be nearly half as expensive as traditional outpatient therapy.

Schrinke, Schiling, Barth, and Gilchrist (1986) described a Stress Management Preventive Intervention (SMPI) for reducing the risk of family violence. Seventy subjects participated in the study. There were 33 subjects in the experimental group. Pre-and postintervention results and a 3-month follow-up assessment showed improvements in the experimental group in the following: parenting competence, cognitive problem solving, and social support.

James (1992) studied the impact of the Control Focussed Therapeutic approach on the stress levels of Black single self-employed female parents in a

public housing community, in four two-hour sessions. The Resident Enterprise Assistance Program was established to provide management and technical assistance to persons resident in public housing communities who were desirous of operating their own businesses. These single parents experienced all of the stressors mentioned in the preceding paragraphs. In addition to these, they articulated the following stressors: (a) the stigma attached to residing in public housing, (b) the sense of loss of control in relation to drugs and crimes in their neighborhood, and (c) the added stressors that low income Black females face in establishing and maintaining a business.

These sessions were part of their certification process to become licensed day care owners. The mean pretest stress levels of the parents was 86 as measured by the Strain Questionnaire which indicated high stress levels. The mean posttest stress levels was 68. Thus, there was an 18 point difference in the stress levels in three weeks. At the conclusion of the workshop there were significant differences in the levels of parenting competence, family adaptability, cognitive stress, physical stress, general stress, cognitive depression, and general depression at the .01 and .05 levels of significance.

These significant differences occurred while the parents were articulating several stressors that they were experiencing. These stressors included (a) awaiting for months the furniture and equipment for their day care centers, (b) attending evening class after a full day's work, and having to be concerned

about the safety and needs of their children, (c) awaiting payment checks which were weeks overdue, (d) awaiting long overdue modifications to their homes for the purpose of conforming to licensing standards, and (e) working with the bureaucracy to obtain their licenses.

Summary

The review of literature revealed that the concept of stress is very pervasive in society today. The models that are used to discuss stress depend on the individual's concept of stress. The cognitive-behavioral and systems approaches to understanding stress focus on the molar and molecular aspects of behavior. In assessing the level of stress experienced by persons, one can focus on either the stressor, the coping/appraisal process, or the stress response.

Stress in families has been associated with child abuse, lower levels of mother-child interaction, lower academic functioning of children, and negative behaviors of sibling interactions. Factors which have been associated with high levels of stress in Black single female parent families can be characterized as: occupational, financial, relational, racial, and low levels of social support.

Single female heads of households continue to request the need for stress management programs. Issues that they want discussed included the development of support systems, time management, child care, parenting techniques, assertiveness training, and consciousness raising.

CHAPTER III

METHODOLOGY

The purpose of this experimental study was to implement a stress management program using the EAR model of Control Focussed Therapy. In this program the levels of stress carried by Black single female parents are addressed. It was envisaged that this reduction in the levels of stress would in turn mitigate the stress milieu experienced by the families of single female parents. The population and sample, hypotheses, research design, relevant variables, treatment model, treatment procedures, instruments, data collection and data analysis are presented in this chapter.

Population

The population for this stress management program was African-American female single parents living in the Hillsborough County of the Tampa Bay area, in the state of Florida. The state of Florida is one of the fastest growing states in the country. Between 1970 and 1980 the U.S. population grew by 11.4 percent, while that of Florida grew by 43.5 percent. This resulted in an increase of 2.95 million persons, which was ranked as the third highest increase in population in the nation (University of Florida, [UF], 1988).

The rapid population growth of Florida has continued in the 1980's. The population of the state grew by 2.3 million between 1980 and 1987, and Hillsborough county experienced the third highest population increase during this period.

Hillsborough county, from which this sample was drawn, is in the South-West area of Florida. The county consists of three cities: Tampa, Plant City, Temple Terrace, and the unincorporated areas. The population of the county grew from 646,939 in 1980 to an estimated population of 801,392 in 1987 (University of Florida, 1988).

The largest city within the county is Tampa. The 1985 test census of which Tampa was one of only two cities chosen in the nation, indicated that the city population was 276,444, with a White population of 162,741; a Black population of 66,050; and an Hispanic population of 39,227. Within this population there were 5,280 White female family headed households; 8,112 Black female family headed households; and 1,088 Hispanic female family headed households (Bureau of the Census, 1986).

In this study, the population is defined as Black female heads of households who had at least one child between the ages of one to twenty-one living with the female parent. The purpose of this workshop was to enable women who are single parenting to effectively manage their stress levels. Individual or group therapy was not provided. The educational level of the

population ranged from mothers who had not completed high school, to those who had graduate degrees.

Sample

The researcher sent to various pastors of Black churches in the Tampa Bay area an announcement of a three session workshop on stress management for single parents. The pastors were told that the researcher would contact them within two weeks to ascertain their interest in having their members attend the workshop. Four pastors responded positively and desired that their members attend the workshop. The researcher then planned a meeting with those pastors. At the meeting the researcher (who is also a pastor) introduced himself, and indicated to the pastors that he was a doctoral candidate and that his dissertation consisted of developing and implementing this study on stress management. The researcher then shared with the pastors a brief outline of the study and emphasized the need to encourage their congregations, especially single parents, to more effectively manage their stress levels. The criteria for selection for the study was also explained to the pastors. The pastors were told that a female single parent who had at least one child 21 years and below living with her was eligible to be a part of the study and attend the workshops. The researcher then asked the pastors for their commitment to advertise the workshops and to encourage their members to attend. The pastors gave their commitment and indicated that they would advertise and encourage their members to attend the workshops. The pastors then decided

on the location of the workshops. The researcher thanked them for their support.

The workshop was advertised by pastoral announcements, inserts in the churches' bulletins, and flyers in the four churches. Forty-nine single parents volunteered to attend the workshop. The researcher used a table of random numbers and randomly assigned those persons into experimental and control groups. Twenty-five and twenty-four persons were placed in the experimental and control group respectively.

As indicated above, forty-nine persons volunteered for the study. Twenty- one persons in the experimental group did the pretest. Eighteen of those persons completed the workshop and took the posttest. Twenty persons in the control group began the study and took the pretest. Sixteen of those persons completed the study by completing the posttest. Thus, 34 persons completed the study. There were 18 and 16 persons in the experimental and control group respectively.

Black female single parents experience severe stressors in our society. Some of the issues they face include role overload, social isolation, racism, parental control, and economic hardship. This last mentioned stressor is very pervasive in the Black community. According to the U.S. Bureau of the Census (1988) over 61% of Black families with children are headed by female single parents, and Black single female households have the lowest income levels of all household types.

The sample for this study consisted of Black female single parents who lived mainly within the city limits of Tampa. Their ages ranged from the 20's to one person in her 50's. Seventeen persons worked full time, and nine reported working from 40 to 60 hours weekly. The marital status of the sample included 15 divorced, 11 never married, and 7 separated single parents. In terms of highest educational level completed, 12 completed secondary, 11 completed technical, 4 had A.A/A.S degrees, and 6 had baccalaureate degrees. In terms of annual household income, 6 persons earned below $10,000; 14 earned between $10,000-$15,000; 7 earned between $15,001-$20,000; 5 earned between $20,001-$30,000; and two earned above $30,000.

Research Hypotheses

1. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of parenting competence.
2. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of family adaptabiity.
3. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported stress related physical symptoms.

4. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported stress inducing cognitions.
5. After adjustment for pretest scores, there will be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of general stress.
6. After adjustment for pretest scores, there will be no significant difference between experimental and control groups participants' mean scores on single parents' reported levels of depression.
7. After adjustment for pretest scores, there is no significant interaction between the level of the single parent's household income and the effects of treatment on the variables of parenting competence, family adaptability, physical symptoms, stress cognitions, general stress and depression.

Research Design

The research design used in this experimental study was that of a Pretest-Posttest control group. In this design, two groups of subjects (an experimental and a control group) were compared on measurements which are the dependent variables. A pretest was given to both groups, and the informed consent forms were signed. The experimental group then received the treatment. Both groups were then given the posttest. In this study, the

experimental and control groups were simultaneously given the pretest half an hour prior to conducting the first session of the stress management workshop. Both groups were measured on the dependent variables of parenting competence, family adaptability, stress-related physical symptoms, stress-inducing cognitions, general stress and depression. The control group was then given a date to attend the second set of workshops. The experimental group then received the treatment (the independent variable) which was a three two-hour session stress management program. On the evening of the third session, both groups were retested for the same dependent variables. The control group completed their posttest prior to the commencement of the third workshop. The experimental group concluded the workshop session with the completion of the posttest.

The workshops were lead by the researcher and a female counselor. To prepare for the workshops, the researcher trained the counselor in the use of the workshop manual (as referenced in the manuscript). The following is a summary of the training procedures conducted by the researcher.

1. A review of the various issues and stressors facing single female parents.
2. A review of the basic concepts and techniques of cognitive-behavioral and structural family modalities of therapy.
3. An introduction to the theoretical framework and goals of Control Focussed Therapy.
4. A discussion of the goals and objectives of the workshops.

5. A discussion of the activities and techniques conducted during each session.
6. A demonstration of the various techniques of Control Focussed Therapy by the counselor to ensure that there was a concrete understanding of CFT.
7. A discussion of any concerns that the counselor had in relation to co-facilitating the workshops.

In any research design there are threats to internal and external validity. Internal validity addresses whether the intervention provided did indeed make a difference in the levels of stress of the participants. External validity addresses the degree to which the results of the study can be generalized to other populations. It is therefore important for the researcher to be cognizant of these various threats and to execute the experiment so as to mitigate the effects of these threats. The pretest-posttest randomized control group design if executed properly, tends to control for most of the internal threats to validity (Borg & Gall 1989; Huck, Cormier, & Bounds, 1974). The major potential threat to internal validity is that of mortality. This would occur if the persons who dropped out from either the experimental or control group were not similar to the other group in terms of variables measured. This would affect the mean posttest scores. A threat to external validity would occur if there was an interaction between the pretesting and the treatment.

Relevant Variables

The EAR model is based on the principles of Control Focussed Therapy. CFT utilizes behavioral-cognitive and systems framework. The researcher

decided to focus on stress related behavioral, cognitive, and systems outcomes that were identified in the body of literature which focused on the construct of stress. The following outcomes were measured: stress-inducing cognitions, stress-related physical symptoms, parental sense of competence, family adaptatbility, and depression.

Stress-inducing cognitions

Stress inducing cognitions was measured by the Strain Questionnaire. The EAR approach addressed this variable by enabling the workshop participants to engage in cognitive restructuring, modeling, role playing, aspiration cognizance, cognitive pacing, period mapping, behavioral rehearsal, and coaching. Persons with high stress inducing cognitions tend to benefit from cognitive restructuring techniques (Lefebrve & Sanford, 1985).

Physical symptoms

Physical symptoms was measured by the Strain Questionnaire. Lefebrve and Sanford (1985), authors of the Strain Questionnaire, stated in reference to various interventions for stress management, "Persons high in physical signs of strain would most likely benefit from both exercise prescription and relaxation techniques" (p. 3). Behavioral relaxation and cognitive restructuring were used to aid in lowering the level of physical symptoms exhibited by the participants.

Family adaptability

The variable of adaptability was measured by the Family Adaptability and Cohesion Evaluation Scales (FACES). Adaptability describes the degree of

change which family members allow within the family system. Families with high levels of stress tend to be very rigid or disorganized. Adaptability was addressed through a systems framework.

Through the EAR approach participants were able to address this outcome variable by engaging in enactment, reframing, feedback, period mapping, cognitive restructuring, communication skills and assertiveness training, and the examination of family of origin issues. In enactment, participants were able to demonstrate the dysfunctional transactions within their family. Participants were given feedback and suggestions for improving their degree of adaptability. Participants engaged in period mapping, which enabled them to be flexible in establishing time frames to focus on specific stressors. Through the process of refocusing, participants began to experience less stress and thus became more flexible in dealing with various stressors. When participants learned to use communication skills more effectively, they were empowered to increase their interpersonal sharing at the emotional level. This in turn led to greater levels of flexibility among workshop participants. Olson (1986), the main author of FACES, indicated that poor communication skills do not facilitate understanding or movement on the adaptability dimension.

Parental sense of competence

The parenting sense of competence variable was measured by the Parenting Stress Index. The sense of competence of the participants was enhanced by cognitive restructuring, boundary delineation, self-reinforcement,

role play, modeling, appraisal, and empowerment. In cognitive restructuring, the participants were aided in identifying and altering their irrational beliefs and negative self statements. In boundary delineation participants were shown how to set parameters in terms of stressors due to time, cognitions, and behaviors. In self-reinforcement training, participants learned to describe themselves in a positive manner. The above techniques aided in increasing the sense of competence of the single female parents.

Depression

The remaining variable of depression was generated from the review of literature, which indicated that depression was consistently present in many women who experienced high levels of stress. Women who experience stress tend to become more depressed than men (Weissman & Klerman, 1977). McLanahan, Wedemeyer, and Adelberg (1981) stated that single female parents tend to have more psychological distress than the rest of the population. The outcome variable of depression was measured by the Beck Depression Inventory. The EAR approach addressed this variable by enabling participants to engage in cognitive restructuring, behavioral relaxation, visualizing, and behavior rehearsal. These strategies lessened the degree of depression among the single parents. Reynold and Coates (1986), in a survey of various studies on stress and depression, found that short term behavioral relaxation training in groups tends to significantly lessen depression. The

process of visualizing, where persons begin to view themselves functioning with lower levels of stress, also tends to lower the degree of life stress.

Treatment Model

The treatment consisted of a workshop held over a three week period, which utilized the EAR approach to stress management. The program consisted of the following objectives:

1. To increase the level of self empowerment, self assessment, and self resolution among participants.
2. To understand the issues of stress and distress and their consequences.
3. To understand the difference between feeling responsible for, and being responsive to the actions of persons.
4. To comprehend the EAR approach to stress management.
5. To enhance the level of hardiness.
6. To recognize the physical, cognitive, and behavioral symptoms of distress.
7. To enable participants to be more effective with time management.

The content of the workshop consisted of the following topics: (a) the nature and sources of stress, (b) the psychological and physiological consequences of stress, (c) personality and coping styles, (d) family systems, (e) and the concept of hardiness. Through the use of various systems, cognitive and behavioral approaches, participants became more cognizant of themselves and the factors that intensify the levels of stress that they experien-

ced. Some of the strategies for managing their levels of stress included cognitive restructuring, focusing, period mapping, cognitive pacing, reframing, enactment, behavioral relaxation, and behavioral rehearsal. The concepts and exercises were presented through various teaching methods which included lecture, discussion, project method, role play, assignment, problem solving approach, and demonstration. The EAR model of stress management is a facet of the Control Focussed Therapeutic approached developed and practiced by the researcher in therapeutic and educational settings. This approach is directive and enables individuals to be in control over their inner dynamics, regardless of whatever occurs within their environment.

This holistic approach views persons as operating within a system. Individuals and their environments are constantly reacting. However, persons can contend successfully with life if they possess certain coping skills and can engage in boundary delineation. The approach consists of three major phases: Empowerment, Assessment, and Resolution (EAR). The EAR process focuses on the feelings, behavior, and cognitions of individuals. Therapeutic intervention can begin in any of these dimensions.

The basic concepts of this approach are (a) persons are born with the capacity to control their lives; (b) many persons learn decontrolling behavior, which render them vulnerable to various degrees of stress; (c) if individuals are aided to self empower, self assess, and self resolve, then the degree of stress which they experience can be decreased.

This approach utilizes the cognitive-behavioral, and systems' concepts of understanding persons. The approach is directive and experiential, and focuses on insight. Strategies include cognitive pacing, boundary delineation, decompression, salience identification, persona enhancement, modeling, cognitive restructuring, coaching, feedback, reframing, enactment, relaxation exercises, guardian designation, behavior rehearsal, status concurrence, period mapping, onus disengagement, and focusing.

The researcher uses Control Focussed Therapy as a treatment modality in a clinical practice. It has been the researcher's observation that the CFT reduces the levels of stress as measured by the Strain Questionnaire on all three subscales. In using CFT, the researcher has also observed reported levels of reductions in major depression, anxiety disorder, and other personality disorders such as passive-aggressive, schizotypal, avoidant, self defeating, and compulsive as measured by the Millon Clinical Multiaxial Inventory II. Positive changes have also been noted on the seeking social support, accepting responsibility, positive reappraisal, and planful problem solving subscales on the Ways of Coping Questionnaire.

Treatment Procedures

This three session workshop utilized a holistic approach to stress management. It was designed to empower female heads of households to more effectively manage their stressors and thus increase the level of control they exercised in the various events of their lives. The EAR approach to stress

management was utilized. This program (which is contained in a manual) consisted of three phases and aided single female parents and their families to lead more fulfilling lives.

Session I

In this session participants were introduced to the first phase of the EAR model which is self empowerment. The theoretical assumption is that when persons become cognizant of, and subsequently comprehend their personhood, environment, and family system, they can initiate the process of effectively managing their lives. Participants were asked to list the various stressors in their lives and were taught that (1) our needs give rise to various expectations; (2) a cognitive gap develops when our expectations and reality do not coincide; (3) this gap can lead to anxiety, stress, and depression. Information was presented on the physical symptoms, cognitive symptoms, and behavioral symptoms of stress. The group then discussed various personality styles and how they affect our management of the cognitive gap. Issues such as persona anorexia, decontrolling behavior, self-esteem, coping styles, self resilience, family systems, world views and religious beliefs were discussed. Participants were taught a behavioral relaxation exercise (Schaefer, 1987).

Participants were then introduced to the second phase of the model which is assessment. In this phase, the issues which had been addressed in the empowerment phase were utilized by the participants to assess to what degree their stance and location on those issues contributed to the levels of

stress they were experiencing. Participants made an assessment on the following dimensions, personality type, ego strength, degree of adaptability, and the degree to which they are dependent on relationships for emotional support (PEAR).

Session II

In this session participants completed the third phase of the model which is the resolution approach. Here, the participants utilized the results of the assessments made in the previous phase and began the process of managing their levels of stress.

The resolution phase consisted of five steps called the PROBE method. First, participants probed the issues which evoked a stress response. The techniques utilized included identification and brainstorming. Second, they restructured their relationships to those issues, so as to deal with stress in a more healthy manner. Thus, a parent who knew that her child had a behavioral problem was asked to reframe the behavior and ask, "What message is this child sending to me by his/her behavior?" Strategies included reality testing, decompression, and reframing. Third, they utilized the process of options establishment. The main purpose was to think of various methods to solve the problem. Here, the main strategies were brainstorming and reframing. Fourth, they engaged in boundary delineation. In boundary delineation the purpose was to lessen the quantitative and qualitative overload of the single parents. Thus, they were encouraged to eliminate activities which, though useful, clearly

overloaded them and increased their stress levels. Strategies included cognitive pacing, salience identification, period mapping, role control, and status concurrence. Fifth, they elected and evaluated courses of actions to manage their stress level. Strategies included visualization, onus disengagement, focusing, coaching, behavior rehearsal, and guardian designation.

Session III

In this session participants viewed and discussed the film "Coping with change: Emotional Fitness" by Spectrum Films. This film demonstrated the development of a hardy personality. Participants applied the concepts and techniques of the EAR approach to the various episodes presented in the film. A discussion on the stressors that the parents were experiencing in the areas of parenting, finances, male relationships, day care, role overload, time management, social support, racism, on the job difficulties, and loneliness was held. The EAR approach was used to address those stressful situations. A behavioral relaxation exercise, "Tense and Relax Neck and Shoulders" (Schafer, 1987), was done.

Instruments

The instruments used to test the research hypotheses included a demographic questionnaire (Appendix A), the Parenting Stress Index, the Strain Questionnaire, and the Family Adaptability and Cohesion Evaluation Scales. The following is a description of the instruments and the outcome variables they measured.

The Parenting Stress Index

This instrument developed by Richard Abdin (1986) was used to measure the sense of competence and depression variables. McKinney and Peterson (1986) stated that "the Parenting Stress Index (PSI) is a parent self-report instrument designed to yield a measure of the relative magnitude of stress in a parent-child system and to identify the sources of stress" (p. 504). There are three main sources of stress identified in the PSI. They are the parent characteristics, child characteristics, and situational/demographic life stress.

The instrument consists of 120 questions. The parent subscale has 54 items. These items measure depression, with a focus on feelings of unhappiness and guilt; parent attachment, that measures the degree of affection between the child and parent, and the degree to which the parent understands the psychological needs of the child; restriction of parenting role, that measures the degree of frustration the parent experiences in fulfilling the parenting role, and the degree to which the parent maintains a self identity; parent's sense of competence, that focuses on the degree of competence experienced by the parent in fulfilling the parenting role; social isolation, that indicates the degree to which the parent is a significant member of various support systems; relationship with spouse, that assesses the degree of involvement in the marital or couple system; and parent health, that estimates the physical and psychological well being of the parent.

The child domain has 27 items that measure adaptability, acceptability, demandingness, mood, distractibility/hyperactivity, and the degree to which the child reinforces the parent. The life stress subscale focuses on potential stressor events that have occurred outside the parent-child relationship during the past year. Such events include a change in marital status, increased financial burden, relating to members of a school staff, employer/employee relationships, and death.

In completing the questionnaire the respondent thinks of the child over which he/she is concerned. Statements are made concerning the relationship between the parent and the child, and the parent responds to the statements where (a) represents strongly agree, (b) represents agree, (c) represents not sure, (d) represents disagree, and (e) represents strongly disagree. The test takes about 20 minutes to administer, and can be either manually or computer scored. The results are given at the subscale, domain, and total stress scores. The questions are written at the fifth grade level.

Development of test

Abdin (1986) developed the test as a result of a review of literature that had focused on parent-child interaction, attachment, child rearing, child psychopathology, and stress. In discussing the assumptions and theoretical bases of the instrument he stated:

> The first was that the instrument would be built on the existing knowledge base. Second, the present effort would be to collate and interface the existing knowledge base with the clinical issues of identification and diagnostic analysis of individual mother-child

> systems under stress. The third major assumption was that stressors or sources of stress are additive. The work of Seyle (1952, 1974) and Rahe (1974) on life stress events supports this assumption. The fourth assumption was that stressors were multi dimensional both as to source and as to kind. This led us to identify three major source domains of stressors. (p. 3)

The research of literature on stress, parenting, and the family context, indicated three domains as needing items to be developed for assessment. Thus, over 95% of the items that have been included in the PSI are directly a result of research findings. An item pool was developed to address certain variables that were frequently obtained in dysfunctional parenting. Experts in child development and psychology rated the items for content validity and the proper construction of items. The experts were also asked to make revision suggestions. Abdin (1986) stated that "the judges' ratings indicated a high degree of face validity for both individual items and the scale as a whole" (p. 4). The items were field tested and revised three times. The mothers were asked for their reactions and suggestions to the items and the administration of the test. The first draft of the test was administered to a sample of 208 mothers, and consisted of 151 items. The subjects were patients of a child clinic in Virginia. The test has been continuously revised. The number of items have been reduced by eliminating items that did not discriminate between high and low degrees of various characteristics.

Burke (1978), in summarizing the development of the PSI, noted that first a review was conducted concerning parent-child interaction, child abuse and psychopathology, and stress. Second, characteristics based on the review

dimensions were identified and items developed. Third, the items were pilot tested for readability, format, and administration. Fourth, six professionals rated the items for content and construction. Fifth, additional field testing occurred, and sixth, a normed population was tested.

The current form of the instrument is Form 6 which was normed on a population of 534 parents. Some of these parents had children with behavioral and health problems, and some children were normal. In describing the normed sample, McKinney and Peterson (1986) stated

> Characteristics of the normative sample of mothers are as follows: 92% were white, 6% were black; income varied with approximately 25% of the families receiving less than $10,000, and 25% receiving more than $20,000 annually; approximately one third were college graduates; ages ranged from 18 to 61, with a mean age of 29.8; the mean number of children living in the home was 1.9; the target children, or children who were the focus of the PSI, ranged in age from one month to 19 years, with a mean age of 14 months and median age of 9 months. (p. 505)

Reliability of the test

The reliability coefficients obtained by the author of the PSI for the norm sample of 534 parents ranged from .62 to .70 for the child domain subscale; .55 to .80 for the parent domain. The reliability for both domains are .89 and .93. The reliability coefficient for the total stress score is .95. The coefficients indicate a more than satisfactory degree of internal consistency.

Abdin (1986) sampled 30 mothers attending a parenting clinic. In the retest of the instrument three months later, there were Pearson correlation

scores of .63 for the child domain, .91 for the parent domain, and .95 for the total stress score.

Burke (1978) administered the PSI to 15 mothers attending a well baby care clinic. The instrument was administered three weeks later and obtained Spearman rank-order coefficients of .817 for the child domain, and .706 for the parent domain. This indicated a significant (p .01) and strong relationship. Zareski (1983), in a study of 54 parents on parenting stress, marital status, and infant development, obtained reliability coefficients of .77 and .69 for the child and parent domains respectively over a three-month period. The reliability coefficient for the total stress score was .88. Hamilton (1980), in a study on the relationship between stress, coping and the quality of infant-mother attachment, sampled 37 mothers. They were administered the test one year later, and reliability coefficients of .55 for the child domain, .70 for the parent domain, and .65 for the total stress score were obtained. These scores reflected strong stability over long periods of time.

Validity of the test

The validity of the PSI has been demonstrated at various levels. Various studies have shown concurrent and construct validity. Lafisoca (1981, 1987) studied the constructs of stress, anxiety, and social desirability. He compared parents of normal children with parents who brought children to a child development clinic. There was a significant correlation at the .001 level between the Child Domain of the PSI and the Child Behavior Problem Check

list. Spielberger (1970) found a significant correlation of .68 between the Parent Domain scale and the State-Trait Anxiety Scale. This correlation is almost the same as that found of .72 between the two parts of the State-Trait Anxiety instrument.

The constructs of stress, self-esteem, and parenting behaviors have also been validated through the PSI. Marsh (1981, 1983) provided strong concurrent validity. Mothers of hyperactive children whose children had greater interactions with the mothers had lower levels of stress and higher levels of self-esteem on the Child and Parent domains.

McKinney and Peterson (1986), in an examination of the Parental Sense of Competence score and the level of spouse support and perceived control, performed a step-wise regression. They discovered that the characteristics of children whose development were delayed contributed the most in predicting the level of maternal sense of competence.

Adamakos, Ryan, Ulman, & Pascoe (1986) studied maternal social support, parenting stress, parent's stimulation, and their interaction with their children. They found that the mothers with high levels of stress had low levels of support. The correlation of -.45 was significant at the .005 level.

Discriminant validity has also been established for the PSI. Lawrence (1982) studied a sample of 89 couples with an only child between the age of 4-12 months. The study was aimed at discovering what relationships existed between the level of husband support and the level of stress experienced by

the wife in her parenting role. The results showed that there was a negative and significant relationship between the three domain scores and four of the five measures of husband support at the .01 level.

Abidin (1982) studied the level of parenting stress and the degree of use of pediatric services for treatment of injuries and accidents by children between the ages of 6 and 48 months. The results suggested that children of low and high stress mothers tended to use the services much more than the parents who had moderate levels of stress. Abidin (1986) interpreted these findings and stated "Low stress (detached) mothers and high stress (disorganized) mothers seemed unable to provide the attention and interactions needed for adequate child care that is likely to lead to fewer injuries and accidents among their children" (p. 25).

Predictive validity has also been established for the PSI. Lafiosa (1981, 1987) was able to identify 100% of the parents of normal children and 60% of the parents whose children attended a development clinic, when the cutoff stress score at the 90th percentile was utilized. Significant mean differences were found for the three major domains.

Zareski (1983) studied the relationships among marital stress, full and pre-term births, infant development at three and six months, and PSI scores for 54 parents. Results from the study suggested that single mothers and mothers of premature babies had significantly higher PSI scores at the .001 level. When the cut-off score of the 75th percentile for the high stressed group and the 25th

percentile for the lower stressed group was used, it was found that all the married full-term mothers were in the low stress group. All the single and pre-term mothers were in the high stress group.

Maternal health behavior is also predicted from the results of the PSI. Wilfong and Abidin (1986) found that, in an examination of parenting stress, the mother's health and the utilization of health services for children between the ages of one and two, and the mother's illness-related behavior had a significant correlation of .42 with the PSI. The mothers in the high stress group had illness-related behaviors 100% higher than the low and moderate stress groups. Abidin (1986) in commentary on these findings stated:

> If these findings can be replicated, they indicate significant potential for the PSI to identify mothers who are likely to make excessive utilization of medical services. Stress reducing interventions are likely to be cost-effective for a PSI identified at risk group. (p. 31)

The Parenting Stress Index has also been used as an outcome measurement instrument. Ribbler, Neumann, Jolicoeur, and Cutshall (1985) measured the effectiveness of cognitive-behavioral therapy on children with Attention Deficit Disorder. The results demonstrated that the treatment made a difference in the interaction between parent and child. This difference was very profound on the subscales of child demandingness, and distractibility or hyperactivity.

The effect of parent education and parent consultation on the levels of stress experienced by parents has been established. Lafferty (1980) used the PSI as a pre and post measure for two groups of parents who had come for

parent education training. There was a significant difference in the Parent Domain Score, Child Domain Score, and Total Stress Score because of the training.

Plough (1980) studied the efficacy of brief consultation (1-8 sessions) for mothers of children up to the age of 10, who were experiencing parenting difficulties. She found a significant reduction in the Total Stress Score after consultation. Abidin (1986) stated that "the Plough and Lafferty studies suggest that the PSI is sensitive to reduction in stress level as a result of psychological intervention and therefore may be a valid measure of intervention effectiveness" (p. 21).

In a critique of the PSI McKinney and Peterson (1986) stated that there are some conceptual problems with the instrument. The subscales of parent depression and sense of competence represent stress responses, while the Child Domain characteristics seem to measure stressors. Thus, there is a mixture of stress response and stressors. For research purposes there needs to be further clarification of items, domains, and scales. There is also a need for researchers to explain the concept of stress without defining stress reaction (McKinney & Peterson, 1986).

Applications of the test

Abdin (1986) indicated that the PSI has been used as a screening tool by physicians, a diagnostic tool by educators, and as an identification tool by educators noting dysfunctional patterns within families before they become

firmly established. Although the normed sample consisted of parents with children between the ages of one month to nineteen years, the norms are most applicable to children below the age of three. For children over the age of three, the norms should be used with caution. The instrument has also been administered to fathers.

The PSI can be administered in various settings. It can be given in either a group or an individual format. There are no special requirements or qualifications needed to administer the questionnaire. The life stress subscale is optional. The PSI is usually completed within 30 minutes. The instrument can be scored manually. The answers are grouped according to subscales, which are in turn grouped according to domains. Domain scores are obtained by adding the various subscales. Abdin (1986) indicated that an individual should take less than five minutes to learn to score the instrument.

The clinical interpretation section of the manual illustrated the basis for interpreting the results of the assessment. The normal range of scores lies between the 15th and 75th percentile. Abdin (1986) stated that the interpretations are based on:

> a mixture of clinical judgements, the relationship of individual items to research outcomes, and the research conducted on the PSI to date. The interpretations suggested should be viewed as working hypotheses, the validity of which will need to be established by further inquiry with any particular client. (p. 39)

The Strain Questionnaire

This questionnaire was developed by R. C. Lefebrve and is a 48-item self-report instrument designed to measure the levels of cognitive, behavioral, and physical stress complaints. The test is usually completed within a 15 minute period. The respondents are asked to reflect on the past week and to indicate how often certain events had occurred. The responses are these: not at all, 1 or 2 days, 3 or 4 days, 5 or 6 days, and everyday.

Development of the questionnaire

Lefebrve and Sanford (1985) in discussing the development of the Strain Questionnaire (SQ) noted that there was a need to develop a content valid instrument that would measure the stress response and focus on the cognitive, behavioral, and physical signs that would correlate with the physical and psychological ailments of stress. In describing the conceptualization and construction of the instrument they stated

> The development of the present scale was guided by the conceptualization of stress (strain) as a syndrome of physical, behavioral, and cognitive symptoms that are elicited, to varying degrees, by environmental demands upon the individual. This syndrome is somewhat independent of concomitant emotional stated (i.e., anxiety, depression) and is not severe or chronic enough to have resulted in clinical diagnoses. (p. 70)

The item pool was created using the stress symptoms enumerated by Seyle (1976) and Lefebreve and Lawis (1979). The 48 items were given to four doctoral candidates in clinical psychology experienced in the assessment and treatment of stress disorders. They were asked to classify the items into

behavioral, physical, and cognitive categories. There were inter-rater reliabilities of .88 to 1.00 among the six pairs of groupings.

The questionnaire was standardized on a sample of 412, which included 285 males and 127 females. The mean age was 33, and the ages ranged from 17-58 years. There were five groups of persons. One group consisted of 100 undergraduate students enrolled in a psychology course. The second and third groups consisted of 38 elementary/secondary teachers and 45 insurance agents who completed the assessment before participating in a stress management program. The fourth and fifth groups consisted of 119 graduate business students and 110 naval engineers. These two groups took the instrument as part of a battery of instruments measuring health behaviors and attitudes.

Reliability of the questionnaire

Reliability results on the Strain Questionnaire for 68 graduate students who retook the instrument one month later have been reported. There were split half values that ranged from .62 on the behavioral subscale to .88 on total stress. Test-retest values ranged from .73 to .79, and Cronbach's alpha values ranged from .71 to .94.

Validity of the questionnaire

Concurrent validity has been established between the Strain Questionnaire (SQ) and the Beck Depression Inventory (BDI) on the sample of

68 graduate business students. The results according to Lefebrve and Sandford (1985) were

> BDI-SQ r=.71; BDI- physical r= .64; BDI- behavioral r=.63, and BDI-cognitive r=.78 (p's .001). These data indicate a moderate degree of shared variance by the 2 instruments (approximately 50%) that is primarily attributable to the overlap of cognitive symptoms (p. 71).

Discriminant validity has also been established for the SQ. Of the five groups on which the test was normed, the only group experiencing low levels of stress was the naval engineers. The students were assessed one week before their final examination, and the teachers and insurance agents had enrolled in stress management workshops. ANOVAs were performed, and significant differences were discovered at the .0001 level. Newman-Keuls analyses indicated that the means of the engineers were significantly lower than the other groups, except on the physical scale. The teachers and insurance agents were found to be very similar in their means on the physical and SQ scale.

The Beck Depression Inventory

This revised 21-item inventory is designed to measure the degree of depression in adults and adolescents (Beck, Rush, Shaw, & Emery, 1979). The inventory replaces the original one which was developed by Beck, Ward, Mendelson, Mock, & Erbaugh (1961). The Beck Depression Inventory (BDI) has been in the vanguard of assessing depression in both psychiatric and normal populations (Piotrowski, Sherry, & Keller, 1985; Steer, Beck, & Garrison, 1985).

Development of the questionnaire

The original BDI was based on symptoms and clinical observations of depressed psychiatric patients, which were rated on a four point scale. In 1971 Beck and his colleagues at the Center for Cognitive Therapy at the University of Pennsylvania Medical School revised the BDI by deleting double negatives and alternative wordings for the same symptoms.

Symptoms and attitudes assessed by the BDI include: mood, sense of failure, guilt, punishment, suicidal ideas, irritability, insomnia, somatic preoccupation, loss of appetite, and loss of libido (Beck & Steer, 1987). The inventory consists of two subscales. The first 13 items constitute the cognitive-affective subscale, and the last eight items constitute the somatic-performance subscale. Beck and Beamesderfer (1974) have suggested cut-off scores for depressed patients. Scores of 0 to 9 are normal, 10 to 18 indicate moderate depression, 19 to 29 indicate moderate to severe depression, and scores above 30 indicate severe depression.

Reliability of the questionnaire

Beck and Beamesderfer (1974) have posited that test-retest estimates of reliability may not be very useful since patients generally experience lowered levels of depression due to therapeutic intervention. Lightfoot and Oliver (1985) obtained a test-retest correlation of .90 during a two week interval with a population of 204 undergraduates. Zimmerman (1986) obtained a test-retest reliability of .64 in a one week interval with 139 undergraduates.

Validity of the questionnaire

Various types of validity have been established for the Beck Depression Inventory. Various studies have demonstrated that the BDI does discriminate between psychiatric and nonpsychiatric patients, and patients with generalized anxiety disorders and major depressive disorders (Steer, Beck, Risking, & Brown, 1986). The BDI also discriminates between dysthymic and major depressive disorders (Steer, Beck, Brown, & Berchick, 1987).

Construct validity has also been established for the BDI. The construct of hopelessness is associated with depression. Lester and Trexler (1974) demonstrated that scores on the Hopelessness Scale Inventory were positively related to BDI scores in all of the six normative samples.

Concurrent validity has also been demonstrated with the BDI. Schaefer, Brown, Plemel, DeMotts, Howard, Petrik, Balleweg, & Anderson (1985) have shown that the correlations between the BDI, MMPI-D Scale, and the Zung Self-rating Depression Scale, in 99 inpatient drug abusers, and 101 psychiatric patients, was greater than .55 for both groups.

The Family Adaptability and Cohesion Evaluation Scales (FACES)

This self-report instrument was used to measure the degree of adaptability within the family context as reported by the single female parents. FACES III measures the degree of cohesion and adaptability within the family system. FACES III is a 20-item instrument that asks the respondents to rank the degree to which certain activities and emotions are present in the family

system. The five responses are these: almost never, once in a while, sometimes, frequently, and almost always. The instrument takes about five minutes to complete and is scored manually.

Development of the inventory

FACES was developed in 1978 by Portner (1981) and Bell (1982) and consisted of 111 items. The major purpose of the instrument was to measure the degree of family satisfaction. Thus, family members were asked to respond to the instrument twice. Initially, they would describe their family as it presently functioned and then respond to the instrument in terms of their concept of the ideal family functioning. In 1981 FACES was revised to produce a much shorter instrument. Double negative items were reduced, and the wording changed so that it could be used with children and other persons with limited reading ability. Factor and reliability analysis were used to reduce the number of items to 30. This consisted of 16 items measuring cohesion, and 14 items measuring adaptability.

In spite of the revisions, FACES II still presented some difficulties. In developing FACES III the authors sought to improve the reliability, validity, and clinical utility of the scales. Olson, Portner, and Levee (1985) stated that some major objectives were:

> (a) to shorten the instrument so it can be administered under perceived and ideal conditions; (b) to develop two empirically independent (orthogonal) dimensions so it better achieves the theoretical criteria of a Circumplex Model; (c) to eliminate negative items so it is easier to score and compare to established norms; (d) to rewrite the ideal version so that it could be more easily understood by family members; (e) to

> develop items that were relevant for a variety of family forms (nuclear, blended, single parent) and couples (married, cohabited) without children; and (f) to have specific norms for adults across the life cycle, adults and adolescents combined for the adolescent stage, and young couples without children. (p. 20)

FACES III is based on the theoretical work of David Olson and Associates at the University of Minnesota (Olson, Russel, & Sprenkle, 1979). In reviewing the literature on family systems, they identified three salient constructs of family dynamics. They are cohesion, adaptability, and communication. These dimensions form the basis for the Circumplex Model of family functioning. Cohesion assesses the degree of emotional closeness between family members. The concepts that are used to assess and diagnose the degree of cohesion are boundaries, coalitions, interests and recreation, emotional bonding, time, space, and friends.

The four levels of family cohesion include low cohesion where there is a high level of individuation, and the family operates in the disengaged mode. On the other end of the spectrum there is a high level of cohesion where the family is described as enmeshed. The two balanced levels of cohesive and healthy family functioning are the separated and connected states (Camara, 1986).

The adaptability dimension of the Circumplex Model refers to the degree to which the family is able to initiate and withstand change. Olson, Portner, and Lavee (1985) defined adaptability as "the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and development stress" (p. 4). The concepts which are

examined in the area of adaptability are the style of negotiation, role relationships, power (which focuses on the degree of control), assertiveness, discipline, and rules of relationships. The adaptability of families can be very low and thus would be characterized as rigid, or they may be very high, and would be classified as functioning at the chaotic level. The two balanced and healthy levels of adaptability are called structured and flexible.

The four levels each of family functioning on the cohesion and adaptability levels give rise to 16 types of family structures. Four of these types would be classified as moderate on the cohesion and adaptability dimensions. Eight types would be extreme on a dimension and moderate on the other, and there are four types that are extreme on both dimensions. FACES enables individuals or families to be placed within the Circumplex Model.

FACES was also designed to measure the degree of family satisfaction by recording the degree of discrepancy between the perceived and ideal state of families. Recently the author of FACES III has modified his stance on the use of FACES to measure family satisfaction. Olson (1988) stated in a letter:

> I am writing to clarify my current position on the use of the Ideal and Perceived version of the FACES III. I no longer recommend using the Ideal-Perceived discrepancy as a measure of family satisfaction for research purposes. The reason for this is that asking a family member about his/her ideal family is too inherently contaminated by social desirability and idealistic distortion factors. I now recommend using a direct measure of family satisfaction, such as the Family Satisfaction Scale that is derived theoretically from the dimensions of family cohesion and adaptability from the Circumplex Model.

One of the major concerns that led to the development of FACES III was that there was a high degree of correlation between cohesion and adaptability on FACES II. Since the premise of the Circumplex Model is that the dimensions are orthogonal, then there was a need to further revise the items to obtain a correlation as close to zero between cohesion and adhesion. The correlation on FACES 11 was .65. A factor analysis of the 50 items on FACES II was done on a sample of 2,414 individuals from nonproblem families. The sample was randomly divided into two. One sample consisted of 1,206 persons, and the other consisted of 1000 adults and 206 adolescents. Through a process of elimination and replacement of items, 20 items were obtained that yielded a correlation of .03 between the two dimensions.

The instrument was standardized on a sample of 2,453 persons that consisted of 1,315 families with adolescents and 242 young couples. Norms are established for three groups. These groups are (a) parents who are across the various family life stages, (b) families with adolescents, and (c) young couples with no children.

Reliability of the instrument

The reliability of FACES III has been measured using Cronbach Alpha for each split sample and the total sample. On the cohesion sub scale the values ranged from .75 to .76. On the adaptability subscale the values ranged from .58 to .63. For the total, scale values ranged from .67 to .68.

Validity of the instrument

Several validation studies of FACES have been done. Olson and Killorin (1984) discovered significant differences between dependent and nonalcoholic dependent families. They reported that only 4% of the nondependent families, while 21% of the chemically dependent families, fell in the extreme range.

Carnes (1985), in investigating sex offenders, reported that 49% and 66% had extreme family types in the families of origin and current families respectively. Nonoffender families had only 19% extreme family types. Balanced family types were found in 57% of nonoffenders, while offenders had only 11% and 19% in their family of origin and current families respectively.

Hanson (1986) in comparing 58 single-female parents and sons found that for the 29 families of the adolescent juvenile offenders that only 7% were balanced, and 93% were mid-range or extreme types. The nondelinquent families had a rate of 69% balance and 31% mid-range or extreme.

Data Collection Procedures

In this study, 49 Black female single parents volunteered to attend the workshop. The researcher randomly assigned 25 and 24 persons to the experimental and control groups respectively. The persons in the experimental group were contacted to confirm their commitment, and the dates, time, and location of the workshops. Persons in the control group were thanked for their interest in attending the workshop, and were informed that they had been selected to attend the second set of workshops. The dates and location were

given for the second set of workshops. The control group was then invited to fill out the pretest on the evening of the first workshop.

The control and experimental groups met half an hour prior to the first workshop in order to complete the pretest. A demographic questionnaire, the informed consent form, and the four instruments which comprised the Parenting Stress Index, the Family Adaptability and Cohesion Scales, the Strain Questionnaire, and the Beck Depression Inventory were administered. The posttest was given to the control and experimental group on the evening of the final session of the workshop. The control group completed their posttest prior to the convening of the final session. The experimental group concluded the workshop session with the completion of the posttest.

Data Analysis

The data from the demographic questionnaire was coded and analyzed using parametric statistics. The analysis was done utilizing the CRUNCH statistical package. Pretest means, posttest means, adjusted means, and standard deviations were used to describe the levels of general stress, depression, parenting sense of competence, physical symptoms, stress related cognitions, and family adaptation.

An analysis of covariance (ANCOVA) was run to identify the differences that occurred in depression, sense of competence, physical symptoms, stress related cognitions, general stress, and family adaptation during the study. To

adjust for the posttest scores for the experimental and control groups, ANCOVA was executed using the pretest as covariate. Three members of the experimental group did not complete the study, and their pretest scores were not used. Four members of the control group did not complete the posttest and their pretest scores were not used. A two-way ANCOVA was run utilizing group and household income as independent variables. The interaction of income and group on the various dependent variables was also studied. The alpha levels were set at .05.

CHAPTER IV

RESULTS

The purpose of this study was to assess the effectiveness of the Control Focussed Therapeutic approach, utilizing the EAR model of stress management for Black female single parents in a workshop setting. The dependent variables were parenting sense of competence, family adaptability, cognitive stress, stress physical symptoms, general stress, and depression. The independent variables included group (experimental or control) and household income (less or greater that $15,000).

The following are the dependent variables and the instruments used to measure them. Sense of competence was measured by the Parenting Stress Index. Family adaptability was measured by the Family Adaptability and Cohesion Evaluation Scales. Physical stress, cognitive stress, and general stress were measured by the Strain Questionnaire. The level of depression was measured by the Beck Depression Inventory.

Resultant Sample

Forty nine Black single parents volunteered for the study. The volunteers were randomly divided into 25 and 24 persons in the experimental and control groups respectively. Twenty-one persons in the experimental group completed the pretest, and eighteen completed the posttest. Twenty control

group members completed the pretest and sixteen completed the posttest. Thus, 18 participants in the experimental group and 16 participants in the control group completed the study.

In this study, there was a mortality of three and four persons in the experimental and control groups respectively. The following is a summary of the pretest scores for those seven persons.

Table 1

Mortality Participants' Mean Test Scores

Dependent Variable	Experimental	Control
Parental Competence	26.66	27.25
Adaptability	26.33	21.75
Physical Stress	45.33	44.00
Cognitive Stress	10.66	11.25
General Stress	78.33	77.50
Depression	9.00	9.50

The following tables illustrate the demographics of the participants who completed the study.

Table 2

Participants' Characteristics by Group and Age

Age	Experimental	Control	Sample
20-29	1	6	7
30-39	10	8	18
40-49	6	2	8
50-59	1	0	1
Total	18	16	34

Table 3

Participants' Characteristics by Group and Weekly Hours of Employment

Hours	Experimental	Control	Sample
None	2	1	3
1-19	3	0	3
20-29	0	2	2
30-40	7	10	17
41-50	3	1	4
51-60	2	1	3
Above 60	1	1	2
Total	18	16	34

Table 4

Participants' Characteristics by Group and Number of Children at Home

Number	Experimental	Control	Sample
1	3	5	8
2	8	9	17
3	3	1	4
4	3	1	4
Above 4	1	0	1
Total	18	16	34

Table 5

Participants' Characteristics by Group and Marital Status

Marital Status	Experimental	Control	Sample
Never Married	3	8	11
Divorced	9	6	15
Widowed	1	0	1
Separated	5	2	7
Total	18	16	34

Table 6

Participants' Characteristics by Group and Educational Level Completed

Level	Experimental	Control	Sample
Secondary	6	6	12
Technical	6	5	11
A.A./A.S.	4	0	4
Baccalaureate	1	5	6
Masters	1	0	1
Total	18	16	34

Table 7

Participants' Characteristics by Group and Years as a Single Parent

Years	Experimental	Control	Sample
1-5	3	10	13
6-10	5	3	8
10-15	6	1	7
16-20	4	2	6
Total	18	16	34

Table 8.

Participants' Characteristics by Group and Annual Household Income

Income	Experimental	Control	Sample
Below $10,000	3	3	6
$10,000-$15,000	7	7	14
$15,001-$20,000	4	3	7
$20,001-$30,000	3	2	5
$30,001-$40,000	1	0	1
Above $40,000	0	1	1
Total	18	16	34

Table 9.

Participants Characteristics by Group and Median Income

Income	Experimental	Control	Sample
Below $15,000	9	10	19
Above $15,000	9	6	15
Total	18	16	34

Research Hypotheses

Research Hypothesis One

In hypothesis one, there was a test to determine whether there was a significant difference after adjustment for pretest scores between the experimental and control group posttest mean scores in the area of parenting competence as measured by the Parenting Stress Index. Table 10 includes the group posttest means, standard deviations, pretest means, and adjusted means for parenting sense of competence.

Table 10.

Group Posttest Means, Adjusted Means, Pretest Means, Standard Deviations for Parenting Sense of Competence

	Experimental	Control	Sample
N	18	16	34
Pretest mean	27.38	29.12	28.20
SD	5.48	4.88	5.20
Posttest mean	29.94	29.81	29.88
SD	4.83	4.70	4.70
Adjusted mean	30.45	29.27	29.88

In the results of the analysis of covariance to test the effects of the intervention on the parenting sense of competence, it was found that there was no significant difference between the experimental and control groups. Table 11 consists of the results of a two way factorial ANCOVA (group x income level) for parenting sense of competence.

Table 11.

Two-Way Analysis of Covariance for Parenting Sense of Competence

Source	DF	SS	MS	F	P
Between groups (E)	1	9.58	9.58	.69	.41
Between incomes (I)	1	5.27	5.27	.38	.54
E X I	1	1.86	1.86	.13	.71

The results of the two-way ANCOVA for the parenting sense of competence showed that there was no significant difference between the experimental and control group. There was also no significant difference between the groups based on income levels. There was no significant interaction between the experimental and control groups and the various income levels. Thus, hypothesis one, that there is no significant difference in the parenting sense of competence for parents who participated in the intervention, is not rejected at the .05 level.

Research Hypothesis Two

In hypothesis two, there was a test to determine whether there was a significant difference after adjustment for pretest scores between the experimental and control group posttest mean scores in the levels of family

adaptability, as measured by the Family Adaptability and Cohesion Evaluation Scales. Table 12 includes the group posttest means, standard deviations, pretest means, and adjusted means for family adaptability.

Table 12.

Group Posttest Means, Adjusted Means, Pretest Means, Standard Deviations for Family Adaptability

	Experimental	Control	Sample
N	18	16	34
Pretest mean	25.00	20.93	23.08
SD	5.87	4.40	5.51
Posttest mean	22.00	20.43	21.26
SD	4.55	4.48	4.52
Adjusted mean	21.22	21.31	21.26

The results of the analysis of covariance to test the effects of the intervention on family adaptability showed that there was no significant difference between the experimental and control groups. Table 13 consists of the results of a two-way factorial ANCOVA (group x income level) for family adaptability.

Table 13.

Two-Way Analysis of Covariance for Family Adaptability

Source	DF	SS	MS	F	P
Between groups (E)	1	.58	.58	.03	0.88
Between incomes (I)	1	6.5	6.5	.37	0.54
E X I	1	35.40	35.40	2.03	0.16

The results of the two-way ANCOVA for family adaptability showed that there was no significant difference between the experimental and control group. There was no significant difference based on income levels. There was no significant interaction between the experimental and control groups and the various income levels. Thus, hypothesis two, that there is no significant difference in the level of family adaptability for parents who participated in the intervention, is not rejected.

Research Hypothesis Three

In this hypothesis, there was a test to determine whether there would be a significant difference after adjustment for pretest scores between the experimental and control group posttest mean scores in the reported levels of stress related physical symptoms. Table 14 includes the group posttest means, adjusted means, pretest means, and standard deviations for stress related physical symptoms.

Table 14.

Group Posttest Means, Adjusted Means, Pretest Means, Standard Deviations for Stress-Related Physical Symptoms

	Experimental	Control	Sample
N	18	16	34
Pretest mean	46.77	47.06	46.91
SD	14.67	14.31	14.28
Posttest mean	39.11	44.43	41.61
SD	7.54	13.63	11.00
Adjusted mean	39.17	44.37	41.68

The results of the analysis of covariance to test the effects of the intervention model on the reported levels of stress-related physical symptoms, showed that there was no significant difference between the experimental and control groups. Table 15 consists of the results of a two way factorial ANCOVA (group x income level) for stress related physical symptoms.

Table 15.

Analysis of Covariance for Stress-Related Physical Symptoms

Source	DF	SS	MS	F	P
Between groups (E)	1	150.58	150.58	1.69	.20
Between incomes (I)	1	147.80	147.80	1.66	.20
E X I	1	56.51	56.51	.60	.43

The results of the two-way ANCOVA for the stress related physical symptoms showed that there was no significant difference between the experimental and control group. There was no significant difference between income levels. There was also no significant interaction between the experimental and control groups and the various income levels. Thus, hypothesis three, that there is no significant difference in the levels of physical

stress symptoms for the parents who participated in the intervention, is not rejected.

Research Hypothesis Four

In hypothesis four, there was a test to determine whether there was a significant difference after adjustment for pretest scores between the experimental and control group posttest mean scores on the reported levels of stress inducing cognitions. Table 16 consists of group posttest means, adjusted means, pretest means, and standard deviations.

Table 16.

Group Posttest Means, Adjusted Means, Pretest Means, Standard Deviations for Stress Inducing Cognitions

	Experimental	Control	Sample
N	18	16	34
Pretest mean	11.88	11.43	11.67
SD	6.57	3.48	5.27
Posttest mean	9.61	10.86	10.05
SD	2.63	3.22	2.92
Adjusted mean	9.53	10.64	10.05

The results of the analysis of covariance to test the effects of the intervention on stress inducing cognitions showed that there was no significant difference between the experimental and control groups. Table 17 consists of the results of a two way factorial ANCOVA (group x income level) for stress inducing cognitions.

Table 17.

Analysis of Covariance for Stress Inducing Cognitions

Source	DF	SS	MS	F	P
Between groups (E)	1	14.24	14.24	2.61	.11
Between incomes (I)	1	19.63	19.63	3.59	.06
EXI	1	.22	.22	.42	.83

The results of the two-way ANCOVA for stress inducing cognitions indicated that there was no significant difference between the experimental and control group. There was no significant difference based on income levels. There was no significant interaction between the experimental and control groups and the various income levels. Thus, hypothesis four, that there is no

significant difference in the level of stress inducing cognitions between the experimental and control groups, is not rejected.

Research Hypothesis Five

In this hypothesis there was a test to determine whether there was a significant difference after adjustment for pretest scores between the experimental and control group posttest mean scores on the reported levels of general stress. Table 18 includes posttest means, adjusted means, pretest means, and standard deviations.

Table 18.

Group Posttest Means, Adjusted Means, Pretest Means, Standard Deviations for General Stress

	Experimental	Control	Sample
N	18	16	34
Pretest mean	80.61	76.56	78.70
SD	22.45	19.22	20.78
Posttest mean	67.88	77.56	72.41
SD	11.76	22.95	18.29
Adjusted mean	66.79	78.79	72.44

The results of the analysis of covariance to test the effects of the stress management model on the general stress levels of the participants in this study showed that there was a significant difference between the experimental and control groups. The participants who attended the workshops reported much lower levels of stress ($F=29.89$, $df=1/32$. $p<.05$). Table 19 consists of the results of a two-way factorial ANCOVA (group x income level) for general stress.

Table 19.

Analysis of Covariance for General Stress

Source	DF	SS	MS	F	P
Between groups (E)	1	1328.78	1328.78	7.58	.01*
Between incomes	1	99.04	99.04	.56	.45
E X I	1	52.83	52.83	.30	.58

* $p<.05$

The results of the two-way ANCOVA for the level of general stress disclosed that there was a significant difference between the experimental and control group, with the experimental group carrying much lower levels of stress. There was no significant difference based on income levels.

There was no significant interaction between the experimental and control groups, and the various income levels. Thus, hypothesis five, that there is no significant difference between the level of stress experienced by the experimental and control group, is rejected.

Research Hypothesis Six

In hypothesis six, there was a test to determine whether there was a significant difference after adjustment for pretest scores, between the experimental and control group posttest mean scores on the reported levels of depression. Table 20 includes group posttest means, adjusted means, pretest means, and standard deviations.

The results of the analysis of covariance to test the effects of the intervention on the level of depression indicated that there was no significant difference between the experimental and control groups. Table 21 consists of the results of a two-way factorial ANCOVA (group x income level) for depression.

Table 20.

Group Posttest Means, Adjusted Means, Pretest Means, Standard Deviations for Level of Depression

	Experimental	Control	Sample
N	18	16	34
Pretest mean	9.33	9.12	9.23
SD	7.97	7.73	7.74
Posttest mean	6.22	7.43	6.79
SD	5.67	7.25	6.65
Adjusted mean	6.16	7.50	6.79

Table 21.

Analysis of Covariance for Depression

Source	DF	SS	MS	F	P
Between groups (E)	1	17.43	17.43	.75	.39
Between incomes (I)	1	.09	.09	.00	.99
E X I	1	7.2	7.2	.31	.58

The results of the two-way ANCOVA for the level of depression indicated that there was no significant difference between the experimental and control group. There was no significant difference based on income levels. There was no significant interaction between the experimental and control groups and the various income levels. Thus, hypothesis six, that there is no significant difference in the level of depression experienced by the parents in the control and experimental groups, is not rejected.

Research Hypothesis Seven

In this hypothesis there was a test to determine whether after adjustment for pretest scores there was a significant interaction between the level of

household income and the effects of treatment on the dependent variables. An examination of hypotheses one to six indicated that there was no significant interaction between the level of household income and the treatment effects on the dependent variables of parental sense of competence, family adaptability, stress related physical symptoms, stress inducing cognitions, general stress, and depression. Thus, hypothesis seven is not rejected.

CHAPTER V

DISCUSSION

The purpose of this study was to assess the effectiveness of the EAR model of stress management which is based on the principles of Control Focussed Therapy. The study was conducted in a three-session workshop setting. This model, which was developed by the researcher, focussed on aiding Black single female heads of households in the Tampa Bay area to reduce their levels of stress. The dependent variables measured were parenting competence, family adaptability, stress-related physical symptoms, stress-inducing cognitions, general stress, and depression. The parenting sense of competence was measured by the Parenting Stress Index. Family adaptability was measured by the Family Adaptability and Cohesion Evaluation Scales. Stress-related physical symptoms, stress-inducing cognitions, and general stress were measured by the Strain Questionnaire. The level of depression was measured by the Beck Depression Inventory. The independent variables were the groups (experimental and control) and the level of household income.

The sample consisted of 34 Black single female heads of households who lived in the Tampa Bay area. The experimental and control groups consisted of 18 and 16 persons respectively. The age ranged from the 20's to

the 50's. The marital status included 15 divorced, 11 never married, and 7 separated parents. The educational level ranged from the completion of secondary school to the completion of baccalaureate degrees. In terms of annual household income, six persons earned below $10,000; fourteen earned between $10,000-$15,000; seven earned between $15,001-$20,000; five earned between $20,001-$30,000; and two earned above $30,000.

The results of the two-way ANCOVA revealed significant differences between the adjusted posttest means for the variable of general stress at the .01 level. There was no significant difference for the variables of parental competence, family adaptability, physical symptoms, stress inducing cognitions, and depression. The level of household income produced no significant difference on any of the dependent variables. There was no significant interaction between group and household income levels.

The remainder of this chapter includes an evaluation of the research hypotheses. Implications and recommendations for further study and a conclusion are included.

Evaluation of Research Hypotheses

Research Hypothesis One

In hypothesis one, it was stated that after adjustment for pretest scores there would be no significant difference between experimental and control group participants' mean scores on single parents' reported levels of parenting competence as measured on the Parenting Stress Index. In this study, the

experimental and control groups had pretest means of 27.38 and 29.12 respectively. The posttest means for the experimental and control groups were 29.94 and 29.81 respectively. The higher the score on the sense of competence subscale of the Parenting Stress Index, the higher is the reported sense of competence and the lower is the stress level as the parent engaged in the daily and challenging task of parenting. This task of parenting is usually made more difficult in female heads of households, where there is generally the lack of the father to assist in the parenting of the child or children. This hypothesis was not rejected at the .05 level. Scores below 23 indicate much stress emanating from the parenting functions. The mean scores of both the experimental and control groups on the pretest and posttest were above scores of 23. Thus, the mothers in this sample did not report high stress scores in the area of parenting. High scores tend to be obtained with young parents who have an only child. Mothers who are limited in child management skills or in knowledge of child development, or who are criticized by the other parent of the child, tend to experience much stress in their parenting function (Abdin, 1986).

Techniques utilized to address the parenting competence of the single mothers included enactment, onus disengaging, persona enhancement, and reframing. In reframing, parents were aided in examining their children's behavior from a different perspective. Thus, in the case of a child who tended to stay out late most nights, parents were asked to think of the possible messages that the child may be conveying to the parent. Parents posited

various possible messages. The parents then brainstormed to suggest various solutions to the possible issues affecting the child.

Emery (1988) noted that the cognitive-behavioral approach enabled women to gain control over their cognitions and thus gain a sense of power and mastery over their lives. McGrath et al. (1990) discussed the use of cognitive-behavioral approaches in increasing the sense of competence among women. The first set of symptoms to be targeted are the emotional. Here women are enabled to realize that their feelings of guilt and anxiety stem from their thoughts and not from themselves. If women are made to engage in tasks that they considered too difficult to be successful, then as they conduct the tasks, they are encouraged to assess whether their cognitions on the task were true. The technique of onus disengagement enabled parents to assess their cognitions which led to an overwhelming burden of feeling very responsible for the behaviors of family members and other significant persons. Parents were enabled to divest themselves of those strong cognitions.

Research Hypothesis Two

This hypothesis addressed whether after adjustment for pretest scores there would be no significant difference between the experimental and control group participants'mean scores on family adaptability as measured by the Family Adaptability and Cohesion Evaluation Scales. An analysis of the adjusted posttest means disclosed that there was no significant difference between the experimental and control group. The hypothesis was not rejected.

Family adaptability or change indicated the degree to which the family was flexible in changing its power structure, role relationships, and its rules of relationships in the presence of either developmental or situational stress (Olson, Portner, & Lavee, 1985). Family adaptability occurs at four levels: (a) rigid, (b)structured, (c)flexible, and (d) chaotic. For families with adolescents, a score range from 10-19 indicated a rigid home environment; a score range of 20-24 indicated a structured home environment; a score of 25-29 indicated a flexible home environment; and a score of 30-50 indicated a chaotic home environment. The pretest mean scores of the experimental and control groups were 25.00 and 20.93 respectively. The posttest means of the experimental and control groups were 22.00 and 20.43 respectively. The pretest scores indicated that the families of both the experimental and control groups were functioning at the balanced level of adaptability.

One possible reason for no significant difference in the area of family adaptability could be location of both the experimental and control group on the adaptability scale. Both groups were functioning at balanced levels of family adaptability. For the experimental group to demonstrate a significant difference with the control group, then the experimental group would have had to obtain mean scores which would be much lower or much higher than that of the control group. This would have placed the experimental group in either the rigid or chaotic zones of family functioning, which represent extreme unhealthy family functioning. This would have been counterproductive to one of the goals of the

workshop, which was to have single female parents and their families function at healthy and balanced levels of family adaptability. Strategies which addressed the dependent variable of family adaptability included enactment, visualization, cognitive restructuring and an examination of family of origin issues.

Research Hypothesis Three

Hypothesis three stated that after adjustment for pretest scores there would be no significant difference between experimental and control group participants' mean scores, on single parents' reported levels of stress-related physical symptoms, as measured on the Strain Questionnaire.

The Strain Questionnaire was normed on 285 males and 127 females. The sample consisted of elementary and high school teachers, insurance agents, naval engineers, and graduate business students. The mean for the normed group was 50.

In this study, the pretest means for the experimental and control group were 46.77 and 47.06 respectively. The posttest means for the experimental and control group were 39.11 and 44.13 respectively. The experimental group had a much lower adjusted mean posttest scores. Lower scores on the physical symptoms subscale of the Strain Questionnaire indicated that the female parents in the experimental group were experiencing less physical symptoms such as backaches, tense muscles, headaches, body weakness, sweaty hands, nausea and diarrhea in their daily lives compared to the control

group. The experimental group had their physical symptoms stress level decrease by 7 points. The control group decreased by 3 points. The hypothesis was not rejected at the .05 level.

It should be noted that in the normed group there were more than twice as many males as females. Questions usually arise as to whether there are gender differences in the physical responses to stress. Lundberg (1983) reported that norepinephrine (the catecholamine which responds more to physical stress) did not discriminate between male and female subjects. In interpreting scores from the Strain Questionnaire the mean has been used to determine if persons are carrying high or low strain. Persons who are at least one standard deviation above the mean are carrying significant strain (LeFebvre & Sanford, 1985).

Workshop activities and strategies were focussed on reducing the physical symptoms of stress. Some of the activities and strategies included behavioral relaxation, abdominal breathing, neck and shoulder massage, boundary delineation, aspiration cognizance, and focussing.

These results are consistent with various studies that have focussed on the relationships between hardiness and health. Kobasa (1979) and Lazarus and Folkman (1984) described studies which addressed the mediating effect of stressors in inducing physical illness and report that as individuals become more hardy, they report less physical symptoms. Weisman and Worden (1975)

showed that patients who were stressed and depressed lived less than those who were less stressed and had a social support network.

Research Hypothesis Four

Hypothesis four stated that after adjustment for pretest scores there would be no significant difference between experimental and control group participants' mean scores on single parents reported levels of stress inducing cognitions, as measured by the Strain Questionnaire. The pretest scores of the experimental and control groups were 11.88 and 11.43 respectively. The posttest means of the experimental and control groups were 9.61 and 10.86. These scores indicated that both the control and experimental group expressed very little cognitive stress. Scores below nine represent reports of no cognitive stress. Low scores indicate less stress emanating from an individual's mode of cognitively processing the events that transpire in every day living. The hypothesis was not rejected at the .05 level.

Research Hypothesis Five

Hypothesis five stated that after adjustment for pretest scores there would be no significant difference between experimental and control group participants' mean scores on the reported levels of general stress, as measured by the Strain Questionnaire. The pretest means for the experimental and control groups were 80.61 and 76.56 respectively. The posttest means for the experimental and control groups were 67.88 and 77.56 respectively. Hypothesis five was rejected at the .05 level. Lower scores indicate lower

levels of stress. Thus, female single parents who attended the workshops acquired coping skills which enabled them to more effectively manage their stress levels than did those parents who were in the control group.

Scores above 80 indicate moderate to slightly elevated levels of stress. Scores below 70 indicate normal levels of stress associated with daily functioning. The pretest mean of the experimental group of 81 indicated that those parents were experiencing slightly elevated levels of stress. The pretest mean of the experimental group was above that of the control group. The following workshop activities and strategies behavioral rehearsal, boundary management, coaching, decompression, onus disengagement, focusing, period mapping, role control, salience identification, and visualization enabled the experimental group to lower their mean stress score by 13 points. According to the reports of several of the parents, onus disengagement was an important technique that helped them reduce their levels of stress. Many of the parents reported that a major stressor in their lives was having a sense of responsibility for their children, their extended families, and significant others. They also felt a sense of responsibility to prove to the fathers of their children and to society that they could be successful. In onus disengagement, persons are taught that they are first of all responsible for themselves. They are also taught the difference between feeling responsible for and being responsive to the events which transpire in their lives.

These results are consistent with other studies which have been conducted to increase the level of coping skills in stress management of women. Tableman, Feis, Marciniak, & Howard (1985) conducted an experiment to examine the effectiveness of stress management training (SMT) as a prevention model. SMT was developed as a multidimensional program to provide an introduction to life coping skills and as a means of helping women feel better about themselves. The program helped the women take more control and learn how to handle stress. The results demonstrated that the trained subjects, were in better mood states and reported a greater perception of control than did the women who did not receive SMT training. Plough (1980) studied the efficacy of brief consultations which ranged from one to eight sessions for mothers of children up to the age of 10 who were experiencing parenting difficulties. It was found that there was a significant reduction in stress levels following consultation.

Research Hypothesis Six

Hypothesis six addressed whether after adjusting for pretest scores there would be a significant difference between experimental and control group participants' mean scores on single parents' reported levels of depression, as measured on the Beck Depression Inventory. The mean pretest scores for the experimental and control groups were 9.33 and 9.12 respectively. The posttest mean scores for the experimental and control groups were 6.22 and 7.43 respectively. The experimental group had a lower adjusted mean posttest

scores than did the control group. Lower scores indicate less cognitive and somatic symptoms of depression. This hypothesis was not rejected at the .05 level.

The Beck Depression Inventory was normed on 944 out patients at the Center of Cognitive Therapy. The diagnoses of this group included personality disorders, anxiety disorders, major depression, (single and recurrent) dsythmic, and psychoactive substance dependence. The mean of the normed group ranged from 27 to 38 (Beck & Steer, 1987). The mean of the sample of this study was 9. Guidelines in clinically interpreting scores derived from the BDI are given by Beck and Beamsederfer (1974). Scores within the range of 0 to 9 are normal or asymptomatic. Scores between 10-18 represent mild to moderate depression. Scores between 19 and 29 indicate moderate to severe depression, and scores above 30 represent very severe depression. Thus, the sample used in this study was not depressed. Workshop activities and strategies targeted to decrease the levels of depression included aspiration cognizance, behavioral rehearsal, cognitive restructuring, guardian designation, decompression, reframing, role control, and status concurrence.

Research Hypothesis Seven

Hypothesis seven stated that after adjustment for pretest scores, there would be no significant interaction between the level of the single parents' household income and the effects of treatment on the dependent variables. The results revealed, that there was no significant difference by income levels.

There was no significant interaction between income levels and group for any of the dependent variables of parenting competence, family adaptability, stress-related physical symptoms, stress-inducing cognitions, general stress, and depression. Thus, the hypothesis that the parents' household income had no significant impact on the intervention by group is not rejected. Thus, whether the single mothers were in the low or high income level, there was no significant differential effect of the treatment.

Implications and Recommendations

The purpose of this study was to assess the effectiveness of a stress management program developed by the researcher utilizing cognitive-behavioral and systemic approaches. The results of this study indicated that there was significant difference between the experimental and control groups on the dependent variable of general stress. The workshop was held over a three-week period, with weekly two-hour sessions.

Theory

Very few stress management programs utilize cognitive-behavioral and systems approaches in stress management. Most of the programs tend to use one approach or, when there is a combination, it tends to be cognitive-behavioral. The Control Focussed Therapeutic approach (James, 1992) which is based on cognitive-behavioral and systemic theoretical orientations, enabled Black single female heads of households to experience a significant decrease in

their levels of general stress. The success of this approach in enabling female single parents to reduce their levels of general stress, may indicate that as we enable persons to take greater control over their lives and to comprehend their stressors in systemic terms, a greater level of empowerment may be occurring. There needs to be an increase in programs which utilize various theoretical combination approaches to stress management.

Training

Psychotherapeutic approaches tend to focus on one or more of the three dimensions of human personality, namely, cognitions, affect, and behavior. Interventions can focus on either the individual or systemic aspects of the problems. The results of this study in significantly reducing the levels of general stress, indicate that counselors who focus on more than one dimension of the individual and combine it with a systemic approach, tend to aid persons to manage their stress levels.

Practice

As we read the print media or listen to the electronic media, we are reminded daily of the various stressors of modern society. In the field of psychoneuroimmunology, much research is currently being done as to the multifaceted effects of stress on the immune system. As the immune system becomes compromised, individuals become more vulnerable to various diseases. The adverse relationship between chronic stress and cancer, diabetes mellitus, peptic ulcer, and the primary killer of persons in this country

cardiovascular disease is well established (Genest & Genest, 1987). As persons become more stressed, they tend to get sicker more often. The astronomical cost of health care has led to various measures such as quality assurance and diagnostic related group procedures in order to curtail health care costs. There is a strong movement to have less costly interventions to maintain good health. Thus, compared to individual psychotherapy, which can be expensive, the results of this study implied that single female heads of households can lessen their levels of stress by attending a workshop. However, workshops cannot replace the need for individual or group therapy when there are issues that need to be addressed in a therapeutic setting. This preventive model of stress management can be used at lesser costs than individual or group psychotherapy.

Research

As mentioned earlier, there is a paucity of research on the combination of cognitive-behavioral and systemic approaches to stress management. This study focused on the effect of combining cognitive-behavioral and structural systemic approaches to stress management. This study needs to be replicated with groups of persons from various ethnic backgrounds, various economic levels, and various occupational levels. Research could also be done on combining cognitive-behavioral and other systemic approaches.

The Control Focussed Therapeutic approach is in its infancy. Thus, much research needs to be done to assess its effectiveness with various

normal populations and with persons who have emotional and psychological disorders. James (1992), in reporting on the use of this approach with seventeen Black female entrepreneurs, noted that significant differences at the .01 and .05 levels were obtained between pretest and posttest on the variables of parenting competence, family adaptability, physical stress, cognitive stress, general stress, and depression.

A limitation of this study is that a few parents missed one of the three sessions. These parents consequently missed some information and the necessary reinforcement to adequately utilize the principles which were new to most of them.

Some recommendations for conducting further research on the impact of Control Focussed Therapy on persons include: (a) increasing the duration of the workshop (and provide baby sitting services), if no significant differences are noted then changes could be made in the focus and content of the program, (b) increasing the sample size so that possible significant differences can be noted, (c) testing the impact of the program on other stress related variables, (d) eliminating some of the present stress related variables if no significant differences are obtained, (e) utilizing other instruments which measure the present variables, (f) assessing the impact of the various stages or techniques on stress reduction, (g) studying the impact of the program on various racial, ethnic and socio-economic groups (h) utilizing other experimental

and non-experimental designs, and (i) conducting follow up studies to note the sustained impact (if any) of the program.

Conclusion

Single female heads of households are a rapidly increasing phenomenon in our society. Some of the problems that female single parents face include economic hardship, role overload, social isolation, feelings of loss and grief, parental control, and time management (Bray 1982; Buehler & Hogan, 1980). These factors lead to stress, not only within the single parent, but also within the entire family. High levels of stress among female single parent families tend to increase the risk of violence, and of sexual and physical abuse to the children in these homes (Tableman, 1982). Levels of stress among female single parent families are strongly correlated with lower academic performance of children from those families (Wyman, Cowen, & Hightower, 1985).

Single parents who are stressed tend to, among other things, (a) have lower levels of parenting competence; (b) experience unbalanced levels of adaptability in their family relationships; (c) have high levels of stress related physical symptoms; (d) engage in stress inducing cognitions (e) experience high levels of general stress; and (f) experience depression. This stress management program (EAR) was used in a workshop setting and utilized cognitive-behavioral and structural theoretical frameworks to enable single female parents to experience a significant reduction in their general stress levels.

The purpose of this study was to test the impact and effectiveness of the EAR model on the stress levels of female heads of households. The dependent variables were the parenting sense of competence, family adaptability, stress-related physical symptoms, stress-inducing cognitions, general stress, and depression. An analysis of the data revealed significant differences on the dependent variable of general stress. Thus, the single parent who experienced the intervention carried lower levels of general stress than their counterparts who were in the control group. An analysis was also made to determine if the level of the parents' income would have had a significant impact on the effectiveness of the intervention. There was no difference noted. There was no interaction between group and income levels on any of the dependent variables studied.

This study demonstrated that it is possible for Black single female head of households who attend a six-hour stress management program held over a three week period, to experience a significant reduction in their levels of general stress, utilizing the concepts and techniques of Control Focussed Therapy.

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APPENDIX

DEMOGRAPHIC QUESTIONNAIRE

Code #_____

Demographic Information

Directions: Please indicate your responses to each question. A response to each question will be greatly appreciated.

1. What is your race? Hispanic_____ White _____Black _____Other_____

2. What is your age? Below 20 ____ 20-29_____ 30-39_____ 40-49____ 50- 59____ Above 60____

3. How many hours are you employed weekly? 0___ 1-19___20-29___ 30-40___ 41-50____ 51-60__ Above 60___

4. How many children below the age of twenty live with you? 1__ 2__ 3___ 4___ Above 5___

5. What is the age of your oldest child living with you? 1-5___ 6-10___ 11-15___ 16-21___

6. What is the age of your youngest child living with you? 1-5___ 6-10___ 11-15___ 16-21___

7. What is your marital status? never married__ divorced__ widowed___ separated___

8. What is the your highest level of education completed? elementary___ secondary___ technical___ A.A___ Bachelors___ Masters___ Post masters ___

9. What is your household income? Below $10,000___ $10,001-$15,000___ $15,001-$20,000___ $20,001-$30,000___$30,001-$40,000___ Above $40,000___

10. How many years have you been a single parent? 1-5___ 6-10___ 10-15___ 16-20___

BIOGRAPHICAL SKETCH

Melvin W. James is president of Alpha Counseling Services in Tampa, Florida, and pastor of the University Church of God in Gainesville, Florida. He graduated with a B.S. in chemistry and theology from the University of the West Indies, and an M.A. and Ed.S. in counselor education from the University of South Florida.

Melvin is a licensed Marriage and Family Therapist, a National Board Certified Counselor, a Clinical Member of the American Association for Marriage and Family Therapy, a Diplomate and Board Certified Sex Therapist, a Clinical Supervisor of the American Board of Sexology, and a Fellow of the American Academy of Clinical Sexologists. As a family and sex therapist, he conducts various workshops and seminars on stress, sex, and the family.

He has constructed the Control Focussed Therapy(CFT) approach which enables persons to manage their "cognitive gap." Utilizing CFT he has developed the EAR model of stress management for clients with adjustment disorders and depression. In April, 1991, he was invited by the Moscow Research Institute of Psychiatry to present on the EAR model of stress management. He also developed the Sexuality Integration Model for persons with various sexual disorders. He is an adjunct professor in the Department of Psychological and Social Foundations at the University of South Florida.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Woodrow M. Parker, Chairman
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Ellen S. Amatea
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Gerado M. Gonzalez
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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